

## In vaginal and cesarean deliveries, a companion is not allowed in the room: discourses of nurses and technical directors

*No parto vaginal e na cesariana acompanhante não entra: discursos de enfermeiras e diretores técnicos*

*En parto vaginal y cesárea el acompañante no entra: discursos de enfermeras y directores técnicos*



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### ABSTRACT

**Objective:** To understand the reasons why health institutions from the state of Santa Catarina, Brazil prevent the presence of a companion in vaginal and caesarean delivery, from the perspective of nurses and technical directors.

**Method:** Exploratory-descriptive, qualitative research. A total of 12 nurses and five technical directors were interviewed from September/2011 to February/2012. The reports were analyzed according to the Collective Subject Discourse.

**Results:** In the central ideas of restrictions to the companion we may cite: the operating room is not the place for a companion; in the delivery room companions are not allowed to come in; the companion does not have emotional and psychological preparation; lack of participation in prenatal care hinders the entrance of the companion; if the companion does not ask, he does not come in, but if he requires, he may come in.

**Final considerations:** The companion impediment is guided by pre-conceived ideas that can negatively interfere in the organization of the birth process.

**Keywords:** Humanized delivery. Social support. Patient's rights. Midwifery. Women's health. Health institutions. Millennium Development Goals.

### RESUMO

**Objetivo:** Compreender, sob a ótica de enfermeiros e diretores técnicos, as razões que levam as instituições de saúde de Santa Catarina (Brasil) a impedirem a presença do acompanhante no parto vaginal e na cesariana.

**Métodos:** Pesquisa exploratório-descritiva, qualitativa. Foram entrevistados 12 enfermeiros e cinco diretores técnicos de setembro/2011 a fevereiro/2012. Os relatos foram analisados segundo o Discurso do Sujeito Coletivo.

**Resultados:** Nas ideias centrais, as restrições do acompanhante são: a sala cirúrgica não é lugar para o acompanhante; na sala de parto acompanhante não entra; o acompanhante não tem preparo emocional e psicológico; falta de participação no pré-natal dificulta a entrada do acompanhante; se o acompanhante não pede, ele não entra, mas se exigir, entra.

**Considerações finais:** O impedimento do acompanhante está pautado em ideias preconcebidas de que ele pode interferir negativamente na organização do processo de trabalho.

**Palavras-chave:** Parto humanizado. Apoio social. Direitos do paciente. Enfermagem obstétrica. Saúde da mulher. Instituições de saúde. Objetivos de Desenvolvimento do Milênio.

### RESUMEN

**Objetivo:** Comprender las razones que conllevan las instituciones de salud de Santa Catarina-Brasil a impedir la presencia del acompañante en partos vaginales y cesáreas, bajo la óptica de enfermeros y directores técnicos.

**Método:** Investigación exploratoria-descriptiva, cualitativa. Fueron entrevistados 12 enfermeros y cinco directores técnicos, de septiembre/2011 – febrero/2012. Los relatos fueron analizados según Discurso del Sujeto Colectivo.

**Resultados:** Las ideas centrales sobre la restricción del acompañante son: la sala quirúrgica no es lugar para el acompañante; en la sala de parto el acompañante no entra; el acompañante no tiene preparación emocional o psicológica; falta de participación en el prenatal dificulta la entrada del acompañante; si el acompañante no pide, él no entra, pero si lo exige, puede entrar.

**Consideraciones finales:** El impedimento del acompañante está pautado en ideas preconcebidas de que él podría interferir negativamente en la organización del proceso de trabajo.

**Palabras clave:** Parto humanizado. Apoyo social. Derechos del paciente. Enfermería obstétrica. Salud de la mujer. Instituciones de salud. Objetivos de Desarrollo del Milenio.

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## ■ INTRODUCTION

The presence of a companion chosen by the pregnant woman, during labor, delivery and immediate postpartum, has been recommended by the World Health Organization (WHO) since 1985, from the Conference called Appropriate Technology for Birth<sup>(1)</sup>.

In the early 90s, based on scientific evidence, this practice has been classified as Care in normal birth: a practical guide, in the category A – practices that are clearly useful and should be encouraged<sup>(2)</sup>. The adoption of this recommendation by health institutions, enables every woman to have the support of a trusted person who belongs to her social network.

The benefits of support during the birth process were highlighted in the last systematic review published by the Cochrane Library, which evaluated 22 randomized controlled trials, in which six of them, conducted in Botswana, Chile, USA, Brazil, Nigeria and Thailand, evaluated the support provided by a companion of choice of women. The main results were: an increase of spontaneous vaginal deliveries; greater satisfaction of the woman with the birth experience; reduction of intrapartum analgesia; reduction of labor time, reduced rates of cesarean sections and instrumental vaginal deliveries; and infants with low Apgar score at 5 minutes of life<sup>(3)</sup>.

In Brazil, the Childbirth Humanization Program, launched in 2000, and Integrality of care for Women's Health<sup>(4)</sup>, in 2004, highlight the importance of promoting the inclusion of companion as one of the humanization practices, qualification and improvement of obstetric and neonatal care. These actions are part of the Brazilian Ministry of health (MH) to reach the fifth objective of the Millennium Development Goal (MDG – 5) – improving maternal health. According to the National report of Monitoring, the goal to reduce maternal mortality rates in three-quarters proposed in 1990, will not be achieved. However, the goal B, regarding the objective – to universalize access to sexual and reproductive health, is close to being reached, since in 2011, most pregnant women held four or more prenatal appointments and virtually all deliveries (99%) were assisted in healthcare facilities<sup>(5)</sup>. The actions proposed go beyond access and coverage, since they seek to promote the adoption of good practice in obstetric attention, such as the insertion of the companion to support the woman during the labor process.

Thus, in 2005, to ensure the presence of a companion during labor, delivery and immediate postpartum as a right of women in health institutions of the Unified Health System

(SUS), in public and private institutions, the law n° 11.108<sup>(6)</sup> was sanctioned, also known as "Companionship law".

In 2011, with the launch of *Rede Cegonha*<sup>(7)</sup>, strategy which aims to ensure the right of women to reproductive planning and humanized attention throughout the gravid-puerperal cycle, the MH once again focused efforts to achieve the fifth MDG. *Rede Cegonha* is an initiative that seeks to change the model of attention to labor and birth, putting the woman as protagonist of the process of pregnancy and labor<sup>(8)</sup>. In this way, it also reinforces the importance of the presence of a companion during the labor process.

Although the insertion of the companion is widely recommended in the Brazilian public policies, the survey conducted by *Rede Cegonha's* audit, in 2012, showed that the hospitals of SUS are not enforcing the law, as from the 83,574 thousand women interviewed, 65.2% reported that they had no right of a companion during the period of labor, delivery and immediate postpartum<sup>(9)</sup>. Other researches also show that many women remain alone, especially during delivery itself, either for vaginal or cesarean deliveries<sup>(10-11)</sup>.

The limiting presence of a companion in the birth setting, in Brazil, forbid women from receiving the support of their social network throughout the labor process. The national survey *Nascer* in Brazil, revealed a social inequality, since women with higher income and education, white, submitted to cesarean section and with private source of payment were more often accompanied by a person of their choice during childbirth<sup>(12)</sup>. Thus, this reveals itself as an important public health problem, since failure to comply with this law deprives woman and the newborn from the benefits of this practice, opposed to the principles of SUS. Consequently, as pointed out by scientific evidence, women are more susceptible to unnecessary interventions during obstetric and neonatal assistance, which adversely affect health indicators<sup>(3)</sup>.

In this context, the guiding question of this study was: what are the reasons for health institutions to not allow a companion of choice of the woman during childbirth? Thus, this research aims to understand the reasons why health institutions from the state of Santa Catarina, Brazil, prevent the presence of a companion in vaginal and cesarean deliveries, from the perspective of nurses and technical directors.

## ■ METHOD

This is an exploratory-descriptive research with qualitative approach, which is part of a greater project enti-

tled "inserting the companion during labor, delivery and postpartum: the reality of the State of Santa Catarina", of mixed method.

This investigation was conducted in the second phase of this greater project, and 12 health institutions that provide assistance to labor. The inclusion criteria were: institutions assisting the birth, where the presence of the companion was disallowed or allowed. Therefore, 12 nurses responsible for Childbirth Center sectors and five technical directors were interviewed, totaling 17 participants.

The number of participants has been set through the theoretical saturation of data, where the collection process is terminated when the information obtained do not bring new elements that deepen or subsidize the desired theorizing on the objectives set by the research<sup>(13)</sup>. In the selection of participants, six of the eight regions of the State were covered – Itajaí Valley, Seaside, West, South, East, North Highlands, Serrano and North Highlands. Among the institutions where the companion was not allowed, there were four nurses and a technical director who refused to participate in the study.

The data were collected from September 2011 to February 2012, through semi-structured interviews, previously scheduled by telephone contact and e-mail. The interview contained questions related to the identification data of the interviewee, professional training, institution's experience in inserting the companion during labor and delivery, opinion of the team on the presence of the companion and discussion of strategies for the implementation of the law. Due to the geographic location of health institutions, the interviews were conducted by phone, recorded with a unidirectional microphone and computer with audio editing software Sound Forge 9.0.

The participants were informed about the objectives of the study, methodology and ethical aspects. The interviews started with the reading and recording of the Consent Form (CF), in which participants verbally agreed to participate in the study and reported the number of their identity document. Subsequently, the audio file with the CF of the participants was sent by email to each one.

All the interviews were transcribed and reviewed, after repeated listening of the recordings. The analysis was performed in accordance with the proposal of the Collective Subject Discourse (CSD)<sup>(14)</sup>. This is a methodological proposal of systemization of qualitative data that assumes the collective thinking can be seen as a set of discourses, composing the social imaginary and expressing the collective talks about a given topic. After reading the empirical material, we identified the key Expressions (KE),

which showed the essence of statements, and the Central Ideas (CI), which described the sense of one or more KE. The language expressions or words that make the CI represent, precisely and synthetically, the placement of a statement or set of KE that formed the CSD, transcribed in the first person of singular<sup>(14)</sup>. In the process of analysis, the KE and CI have undergone a process of validation by the researchers, as the findings were discussed to settle any contradiction<sup>(13)</sup>.

The macro project has been approved by the Research Ethics Committee of the State Secretariat of health of Santa Catarina, Protocol No. 0026.1602/09, and all aspects involving the performance of this research are in line with the resolution No. 196/96 of the National Health Council.

## ■ RESULTS AND DISCUSSION

Nurses interviewed (12) were mostly female, aged between 27 and 48 years, and with time of experience and training from two to 24 years. Only one had a certificate in obstetrics and three were attending a course on the topic, and the time of experience in the area of obstetrics ranged from one to 24 years. The technical directors (five) were all male, aged between 34 and 67 years, time of experience and training ranging from three to 40 years, working as technical director between three months and 15 years, and one had a degree in Nursing, one in Pharmacy and three in Medicine.

After the analysis of the statements of the participants, five central ideas emerged: the operating room is not the place for a companion; in the delivery room companions are not allowed to come in; the companion does not have emotional and psychological preparation; lack of participation in prenatal care hinders the entrance of the companion; if the companion does not ask, he does not come in, but if he requires, he may come in. The CIs and their corresponding CSD were identified by the same numbering.

### **CI1 – the operating room is not the place for a companion**

*(CSD1) I think because this procedure[caesarean section] is more invasive, a surgery, I think it's more complicated, it's a little disturbing scene for them [companion], they are terrified, and the guy is going to pass out. Then, the situation will be complicated. The companions are not used to the concepts of using antisepsis and asepsis, all the special clothes to be in the operating room, to deal with the sterile field.*

The CI1 and her CSD demonstrate that professionals believe that the operating room is not an environment for the companion. The C-section, because it is a major surgery, requires the adoption of practices that the companions are not familiar with and therefore, do not know how to behave. In addition, limiting the entry of people who are not part of the team seems to spare the professionals from unpredictable care demands, which helps to understand why the companion's presence in the operating room is less frequent than in the room of vaginal delivery<sup>(10)</sup>.

The professionals do not recognize that women have the right to have a companion in the operating room, and consider that they will get in the way of assistance because they are unprepared, and thus increase nervousness and anxiety situations to misinterpret the service provided to the pregnant woman<sup>(11)</sup>. However, it is also the health team responsibility to identify companions' demands in this environment, reassuring and clarifying their questions regarding procedures performed.

It is worth noting that one of the major challenges for the Brazilian health policy and for reaching the fifth MDG is the reduction of indiscriminate use of Cesarean sections, because this procedure contributes to increased rates of maternal and neonatal risks and has hampered the reduction of maternal mortality. The rates have remained very high and with a tendency of growth in all Brazilian regions<sup>(5)</sup>.

## CI2 – In the delivery room companions do not come in

*(CSD2) It is said that you can't [during childbirth], that it is a rule of the institution. Nothing is explained, it's kind of short and straight. We don't always have the companion in the delivery room, and even less on Cesarean delivery, but before labor and immediate postpartum, they always have a companion. When they go to the delivery room [labor] they are alone. If they get into the hospital during labor, they are directly taken to the delivery room, nobody stays together, just after postpartum.*

The modification of routines that may change the operation of the Obstetric Centre (OC) appears to be a limiting factor of the companion entry. Study that described the insertion of the companion in Santa Catarina showed that 15.3% of the institutions do not allow the presence of the companion in the delivery room, pointing out as difficult aspects, the inadequate physical area, the lack of support from the technical, administrative and clinical

directory, the non-acceptance by professionals working in the OC, and no claim of pregnant women<sup>(10)</sup>. National data indicate that from the 23,879 women interviewed, only 32.7% of them had a companion at time of delivery<sup>(12)</sup>. In this way, the CI2 contributed to the understanding of this reality, since she shows that some institutions restrict routinely companion's presence as an institutional rule, not promoting their insertion.

Whereas the evidence about the benefit of supporting the woman, through the companion of their choice, points to a reduction of unnecessary obstetric interventions<sup>(3)</sup>, one can infer that the adoption of this practice in the institutions of health contributes to the achievement of the fifth MDG, as the reduction of maternal mortality by obstetrical causes is subject to reduction of complications in childbirth and puerperium arising from inadequate interventions<sup>(5)</sup>. In this way, it is essential that all efforts should be made so that this good practice is implemented for all pregnant women in labor.

## CI3 – The companion does not have emotional and psychological preparation

*(CSD3) Some companions aren't prepared, as much as we do the whole orientation of the procedure itself, especially in the delivery room, I've had a few situations that the companions want to participate, but when the moment came, they had no psychological conditions to do it. And some situations that will occur inside were not explained to him and he might find it weird. There has to be a criterion, a good idea of how the person will behave during the procedure. Then, based on my experience I know how they may act. I see some fathers who don't come prepared for what they will see, what's going on, you know?*

It is possible to identify in this statement from the CI that, in the view of professionals, the companion must have a prior knowledge of the phenomena, they are involved in childbirth so that they may have adequate participation in this process. This perception that the companion has no preparation can be due to the beliefs, values and preconceived ideas that lead the professional not to accept the presence of the companion during delivery<sup>(15-16)</sup>. However, the "unpreparedness" of the companion, reported by professionals, cannot be a justification for non-permanence in the scenario of childbirth<sup>(17)</sup>.

The professional assumes that the behavior of the companion is predictable and that he or she has the experience needed to identify in advance his reaction

at the scene of childbirth, that is, he or she knows who will or will not get in the way. In a research conducted in a maternity ward in the Northeast region, the professionals believed that the presence of a companion could interfere and cause changes in the dynamics of work<sup>(18)</sup>. This CSD is closely related to the next CI, since, from the perspective of professionals, the companions are not prepared to face the emotional demands associated with childbirth, causing erroneous ideas about how they will behave. On the other hand, research conducted with companions revealed that the experience in the OC was extremely positive, surpassing negative expectations, despite the lack of preparation<sup>(19)</sup>.

These aspects refer to a reflection on the importance of the professionals to know and value the diversity of feelings, emotions and anxieties involving the companion experience in OC and provide the necessary support<sup>(19)</sup>.

The CSD3 also demonstrates that the health professional tends to allow the companion when he or she considers that the delivery will be "normal", that is, selecting a standard of "ideal delivery" so that the companion may have a good experience. This conception seems a bit misplaced when rescuing the benefits of support during the childbirth, as it helps with the physiology of childbirth, reducing obstetric interventions and women's satisfaction with the experience<sup>(3)</sup>, creating a virtuous cycle in which the companion is a critical instrument.

#### CI4 – Lack of participation in prenatal hinders the entrance of the companion

*(CSD4) The monitoring of delivery will depend on whether the person was or was not in prenatal care, during the appointments, then, they may come in. You see, when the time for delivery comes, the baby's father always wants to watch, but then he didn't attend any prenatal appointments, he did not participate, he wasn't advised during prenatal care. So, during some moments, his presence is not allowed in the delivery room. The way that they do not participate [prenatal care], hampers his insertion in the operating room.*

The Companionship law guarantees the right of women to have someone of their choice during labor, delivery and immediate postpartum. Although it does not determine criteria to be a companion, the CI4 and her CSD showed that the professionals condition their presence to the participation during prenatal care.

One has to consider that the groups of pregnant women and pregnant couples during the prenatal period

are an important strategy in emotional and instrumental preparation of the companion for delivery. However, in the Brazilian context, not all pregnant women, neither companions, can attend these groups. The prenatal consultation is the main strategy to engage the companion of choice of women from pregnancy to make him or her to feel secure and empowered to participate actively in the process of pregnancy, and should consider the demands related to the preparation for childbirth. In this sense, it is necessary to broaden the scope of actions beyond the coverage and access of women to prenatal care, in the intention of contributing to the reduction in the rates of Cesarean sections, which impact directly on maternal mortality<sup>(5)</sup>. Therefore, primary health care professionals should stimulate the companion to attend the appointments, guiding them on their role as a provider of support<sup>(19)</sup>.

However, participation in the prenatal period is not a *sine qua non* condition to allow the companion into the room during all clinical periods of labor, in particular at the time of the "childbirth itself". In this sense, it is imperative that OC professionals also provide the guidelines necessary to ensure that the companion can support the mother and have a positive experience.

#### CI5 – If the companion does not ask, he does not come in, but if he requires, he may come in

*(CSD5) – if the companion does not ask, he does not come in. If he asks, then ... he comes in. [...] Well, actually we don't even mention the subject, the team also doesn't insist on it. Because we have no way to care for him inside the Obstetric Center. We guide the procedures that will be made and the reasons why he can't accompany, but if they require, really demanding, saying what they want, we have no way to say no. But, as almost no one asks, then, the entry is rare. So, it's not so common the companion in the delivery room, or in the operating room.*

The professional power forbids the presence of the companion, so the publication of law No 11.108 in 2005, by itself, did not secure that right for all women. National survey data from *Nascer project*, in Brazil, showed that only 18.8% of women had a companion at all times of admission<sup>(12)</sup>.

The findings of this study contribute to understand this national scenario, since it reveals how professionals omit information about the law from the companion and have strategies to prevent its implementation. Thus, if the companion does not ask, the institution also does not



care about their presence, but if he requires, the permission is granted.

In this context, the broad dissemination among the users of health services, with reference to the law No 12.895<sup>(20)</sup> which requires hospitals to keep the information in a visible place about the right to companion seems to be the most effective strategy, so that they can assure social control. At the same time, it is the responsibility of health professionals and managers to change their attitude in order to enforce compliance with laws related to companion.

The insertion of the companion is a practice that can cooperate in promoting qualified women care, one of the major initiatives in the main theme of health for the MDG<sup>(5)</sup>, since it is essential to the humanization of care. In addition, their support during labor, delivery and immediate postpartum contributes to a reduction of unnecessary intervention and consequently helps to improve maternal health.

## ■ FINAL CONSIDERATIONS

The prohibition of the companion's presence in the scenario of vaginal births and cesarean sections prevents not only the woman's right to be respected, but also the newborn's right to enjoy the benefits of the practice.

The obstacles imposed by health professionals, for full compliance with the Companionship law, are guided by preconceived ideas that the hospital environment is not the place for a companion and that their presence may interfere negatively in the Organization of the work process.

The reasons pointed out in the discourses of professionals reinforce the biologicist model, which is still predominant, despite public policies for attention to women's health and newborns, from the principles recommended by the SUS and the efforts made by the MH to the goals established by the fifth MDG.

The insertion of the companion in the birth process requires changes in attitudes of professionals, in particular those that occupy management positions in health institutions, whether from the medical or nursing fields. In this perspective, nurses have a central role in the planning of health actions, with managers, aimed at inserting the companion. The adoption of this practice can contribute to the reduction of unnecessary inducing interventions of obstetric complications, which in turn are associated with maternal mortality in Brazil, which remains above the goal set for 2015 by the MDG.

Finally, the findings of this study contribute to a wider reflection on the issues related to the insertion of compan-

ions and its interface with reaching the fifth MDG, pointing to opportunities for this practice to be more valued in the promotion of a safe and qualified service to women.

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