Original Article

The companion in the obstetrics centre of a university hospital in southern Brazil

O acompanhante no centro obstétrico de um hospital universitário do sul do Brasil

El acompañante en el centro obstétrico de un hospital universitario en el sur de Brasil

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ABSTRACT

Objectives: To verify the prevalence of companions, their type of bond with the women and the justifications for their absence in the obstetrics centre of a university hospital in Porto Alegre (RS).

Methods: Quantitative, cross-sectional study carried out with 385 females from August to November, 2012. The data were subjected to descriptive analysis.

Results: Of all the companions, 97.1% were present during labour; 90.6% were present during delivery; 28.6% throughout postpartum care; and 87.1% during the first care procedures of the newborn baby. Most of the companions were the women's partners. The most frequently mentioned reason for their absence during the postpartum recovery period was "not allowed" (57.8%).

Conclusions: The healthcare institution observes the legal provisions for the presence of a companion, but there is still the need to build awareness among healthcare professionals on the importance of companions during the moments following childbirth, and to adapt the location to accommodate the companions who will support the women.

Keywords: Humanizing delivery. Parturition. Medical chaperones. Millennium Development Goals.

RESUMO

Objetivos: Verificar a prevalência de acompanhante, o tipo de vínculo com a mulher e as justificativas para sua ausência no Centro Obstétrico de um hospital universitário de Porto Alegre (RS).

Métodos: Estudo quantitativo, transversal, realizado com 385 mulheres no período de agosto a novembro de 2012. Procedeu-se à análise descritiva.

Resultados: Constataram-se 97,1% de acompanhantes no trabalho de parto; 90,6% no parto; 28,6% na recuperação pós-parto; e 87,1% na realização dos primeiros cuidados com o recém-nascido. O companheiro da mulher foi o acompanhante predominante em todos os momentos. O motivo mais citado para a sua ausência na recuperação pós-parto foi "não permitido" (57,8%).

Conclusões: A Instituição cumpre as determinações legais referentes à presença de acompanhante, no entanto, ainda há necessidade de sensibilização dos profissionais de saúde quanto à importância do acompanhante no pós-parto imediato, assim como de adequações do espaço físico do local, favorecendo a presença desse suporte à mulher.

Palavras-chave: Parto humanizado. Parto. Acompanhantes formais em exames físicos. Objetivos de Desenvolvimento do Milênio.

RESUMEN

Objetivo: verificar la prevalencia del acompañante durante la permanencia de la mujer en el Centro Obstétrico, el vínculo de éste con la paciente y los justificativos en caso de su ausencia en este Hospital Universitario de Porto Alegre (RS).

Método: Estudio cuantitativo transversal, realizado con 385 mujeres en el período desde agosto a noviembre de 2012. Se procede al análisis descriptivo.

Resultados: 97,1% de acompañantes durante el trabajo de parto; 90,6% en el parto; 28,6% durante la recuperación postparto y 87,1% en la realización de los primeros cuidados al recién nacido. El compañero de la mujer fue el acompañante predominante en todos los momentos. El motivo más referido para la ausencia en la recuperación postparto fue "no permitido" (57'8%).

Conclusiones: La Institución cumple con las determinaciones legales referentes a la presencia del acompañante, sin embargo, aún existe la necesidad de capacitar a los profesionales de salud en la importancia que tiene el acompañante durante el postparto inmediato, así como adaptar el espacio físico del área, favoreciendo la presencia dando soporte a la mujer.

Palabras clave: Parto humanizado. Parto. Chaperones médicos. Objetivos de Desarrollo del Milenio.

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INTRODUCTION

Parturition is a singular event in the lives of women that involves biological, psychological and social transformations. The manner in which this process is observed and managed by healthcare professionals will positively or negatively affect the individual experiences of these women and of their families.

Until the 19th century, labour and childbirth occurred in the home environment, where women were assisted by other women of their trust, called midwives, and surrounded by family members who gave them support. With the advancement of obstetric technology and the consequent institutionalisation of labour, the family members stopped being a part of this scenario and the women were inserted into hospital routines, which hinders individualised care[1].

In an attempt to reintroduce the people who are close to the women in the process of parturition, the Brazilian Ministry of Health implemented Law 11108 of April 7, 2005. The law stipulates that the health services of the Unified Health System (SUS), provided by the public network itself or privately, must allow the presence of a companion freely chosen by the mothers during the entire period of labour, birth and the immediate postpartum[2].

Even with the legal presence of the companion, there are obstacles regarding the implementation of this law due to inadequate infrastructure and services, especially the lack of preparation and capacity of the healthcare team to manage this requirement[3].A woman's right to have the companion of her choice for the entire parturition process is not only guaranteed by law; it is also advocated by the World Health Organization (WHO)[4] and by Brazilian government programmes that reinforce the importance of the practices that promote humanized labour and birth.The aim of thishumanization is to reduce unnecessary interventions and promote parturition and birth as a unique, natural, physiological process that depends on the empowerment of women[5].

The presence of companions throughout the pregnancy and puerperal cycle converge upon the fourth and fifth Millennium Development Goals, which refer to reducing child mortality and improving maternal health[6], respectively, since the presence of companions has a positive impact on the qualification of care provided to newborns and their mothers. The most recent systematic review on this issue revealed that women who had continuous support during parturition were more likely to have a spontaneous vaginal birth, shorter labour, less chance of intrapartum analgesia and greater satisfaction of the birthing process[7], all of which help reduce the risk of maternal morbidity and mortality. As regards to the newborns, it was observed that they have a better chance of obtaining a higher Apgar score in the 5th minute when the mothers has a companion in the delivery room due to the lower number of interventions and the subsequent improved vitality of the newborns[7].

Companions in the obstetrics centre recognize their presence as a source of support for women, even in the face of the difficulties and stressful situations that are new to laypersons. However, the companions tend to overcome their fears and adapt to the situations they are forced to confront in the process[8].

The advantages of companions are recognised by health professionals, although they believe their presence can disrupt their work at the obstetrics centre and they do not identify companions as a legally constituted right[9]. A study that specifically addresses the father as the companion shed important light on the different perceptions of health professionals. There are those who are disturbed or who do not agree with the presence of the father, while others, such as nurses, who are academically trained to focus on social, humanitarian and emotional issues, are more likely to accept the presence of the father during labour[10].

A study on breastfeeding carried out in 2012 in the obstetrics centre of the Hospital de Clínicas de Porto Alegre found a high prevalence of companions chosen by the women in the delivery/C-section room (94.4%) and a reduced percentage (51.2%) of companions in the recovery room, although the study did not provide reasons for this difference[11]. This revealed the need for further studies on the subject to know how frequently companions are present in all the stages of women's care in the obstetrics centre, including in the first care of the newborn (admissions room), and the reasons for the absence of companions in the postpartum room and the newborn admissions room.

To ensure effective humanitarian assistance that complies with the law and focuses on the needs of women and their families, it is necessary to implement measures that are capable of overcoming the current obstacles and of connecting these laws to the practices. Consequently, the aim of this study is to verify the prevalence of companions, the type of bond with the women and the justifications for their absence in the obstetrics centre of a university hospital in Porto Alegre, RS, Brazil.

MATERIALS AND METHODS

This is a quantitative cross-sectional study that consisted of a sub-analysis of a study entitled "*Práticas de Aten-*

dimento implementadas durante o processo de parturição", conducted at the inpatient obstetrics unit of the Hospital de Clínicas de Porto Alegre (HCPA).

The sample consisted of 385 recent mothers and their newborns. The sample was calculated according to the number of births at the institution in 2010. The sample included women who had vaginal delivery and c-section in the obstetrics centre of the institution, with a single gestation of 37 weeks or more according to the Capurro method. The criteria for exclusion were women who had not gone into labour, who had undergone an elective or emergency c-section and women who had suffered foetal death or who had given birth to babies with malformations.

The data were collected from August to November 2012, 12 hours postpartum, using a structured questionnaire, electronic maternal and neonatal medical records and the event sheet of the restricted area of the obstetrics unit.

The data were used to characterise the sample (demographics and obstetrics), the presence of companions of the women during their permanence in the pre-delivery, delivery/caesarean, recovery and newborn admissions rooms and the justification for the non-permanence of companions in the recovery and newborn admission rooms, since a previous study indicated the reduction of percentages in relation to permanence in the other rooms[11].

The studied variables were subjected to descriptive analysis using measures of central tendency and percentages. The analyses were completed using SPSS software, version 18.

The research that led to this study was approved by the Research Committee of the Escola de Enfermagem da Universidade Federal do Rio Grande do Sul and by the Research Ethics Committee of the HCPA (120150). Research complied with the terms of resolution No. 466/2012, of the National Health Council[12]. All women who participated in this study, or the persons responsible in the case of participants under the age of 20, signed an informed consent statement. A disclaimer for the use of institutional data was submitted to the institution.

RESULTS

Most of the 385 women were white (55.1%) adults (78.2%). With regard to education, the majority of the women (61.3%) had not finished secondary school. In terms of occupation, the percentages of women who were homemakers and of women who worked outside the home were similar. Most women had a partner and had attended prenatal care (99.7%). The physician was responsible for providing most of the prenatal care (70.3%). Among women who received prenatal care, 81.7% reported having attended six or more consultations. In 53.1% of the cases, this was not the first pregnancy, and 75.1% of the women had delivered their babies by vaginal birth (Table 1).

Figure 1 shows that the highest percentage of companions (97.1%) was in the pre-delivery room and that 26.2% of the women had a companion in all the rooms during their permanence in the centre[d].

Figure 2 shows the type of link between the women and their chosen companions in the pre-delivery, delivery/caesarean, recovery and newborn admissions rooms. It was found that the partners were more frequently present in the pre-delivery rooms and the delivery/caesarean rooms, followed by the women's mothers. The category "Others" includes the following companions: cousin, grandmother, mother-in-law, stepmother, father and doula.

In the recovery room, 28.6% of the women had a companion. Among the women who did not have companions, seven reasons for this absence were identified (Table 2). The reason "not allowed" was the most frequent (57.8%) of this sample. It should be noted that the reason for absence was only investigated for the recovery room, since previous studies reveal a significant reduction of companions in this room[11].

When the companions chose to be absent, the main reasons mentioned by the women were: need to rest; eat and perform personal hygiene; scheduled commitment; get clothes for the newborn and wife; take care of other children; and personal reasons. Inadequate physical space, which was reported by 2.9% of the women as being a reason for the non-permanence of their companions in the recovery room, was reported as: companion leaving the room for the recent mothers to have some privacy; overcrowded recovery room; physical space was insufficient or inadequate for the companion.

During the provision of care for the newborn in the admissions room, 12.9% of the women reported the absence of their companion and presented four justifications (Figure 3), of which "my companion did not want to stay" was the most prevalent (58%).

[d] The companions in the delivery/C-section room, in the recovery room and in the newborn admission room were the same, since switching companions is not allowed in restricted areas.

Table 1 – Characteristics of the 385 recent mothers included in the study. HCPA, Porto Alegre/RS, 2012

Characteristics of the recent mothers / Sociodemographic Variables	n	%*
Age		
14 - 19 years	84	21.8
20 - 44 years	**301**	**78.2**
Skin colour (self-declared)*		
White	**211**	**55.1**
Black, dark complexion, *mulatto* or brown-skinned	163	42.6
Others	9	2.3
Education		
Incomplete elementary school	98	25.5
Finished elementary school	64	16.6
Incomplete secondary school	74	19.2
Finished secondary school	**117**	**30.4**
Incomplete or finished higher education	32	8.3
Occupation		
Exclusive homemaker	157	40.8
Activities other than homemaker	**181**	**47.0**
Students	37	9.6
Unemployed	10	2.6
Marital Status*		
With partner	**345**	**90.1**
Without partner	38	9.9
Category of admission*		
SUS	**380**	**99.2**
Medical insurance or private	3	0.8
Prenatal		
Attended prenatal consultations		
Yes	**384**	**99.7**
No	1	0.3
Prenatal care provider*		
Doctors	**270**	**70.3**
Doctors and nurses	111	28.9
Nurses	3	0.8
Number of consultations*		
< 6 consultations	70	18.3
≥ 6 consultations	**313**	**81.7**
Obstetrical		
Number of pregnancies including the current pregnancy**		
One	180	46.9
Two or more	**204**	**53.1**
Type of labour		
Vaginal	**289**	**75.1**
Caesarean section	81	21.0
Vaginal with forceps	15	3.9

*2 data lost ** 1 data lost
Source: Research data, 2012.

DISCUSSION

In relation to prenatal monitoring, almost all of the recent mothers (99.7%) reported having attended the consultations and 81.7% reported having attended at least six consultations, as recommended by the Ministry of Health in its prenatal and birth humanization programme[13]. Research that investigated whether companions are aware of their legal right to accompany the new mothers revealed a wide range of sources of information, including their social network, the companion's wife, the media, maternity professionals and previous experience as a companion[8]. This highlights a gap in educational actions during prenatal care, since the right moment for women and their companions to receive guidance on Law 11108 is during the consultations or in prenatal support groups. There is evidently a mismatch between the frequency and the quality of the prenatal guidance the women and their companions receive. In this study, the prenatal consultations the women attended were exclusively provided by doctors, whose practice mainly focuses on curative aspects in accordance with the biomedical model of care they are exposed to during their studies.

Research at the same institution showed that the presence of the father of the newborn during labour and delivery is directly linked to the involvement of the father during the prenatal period. This reveals that the participation of the father in this period fundamentally prepares him for the moments prior to delivery. In the same study, many fathers reported the absence of information on the law of the companion during the prenatal consultations, which made it impossible for them to assert that right at the pre-delivery and delivery stage[3].

A recent study with mothers and fathers in several UK maternity hospitals found differences in paternal engagement during prenatal care, childbirth and postnatal care/childbirth that depended on some maternal characteristics, such as primiparity, white, higher education, lives in a privileged neighbourhood and planned pregnancy. Thus, it is important that health professionals acknowledge that some women may get less support from their partners and may therefore be more dependent on carers in maternity wards[14].

The data obtained in this study showed that almost all the women in the sample had a companion during pre-delivery (97.1%) and childbirth (90.6%), which is positive for the humanization of childbirth advocated by the World Health Organization[4]. However, if we consider the presence of companions during the entire prepartum

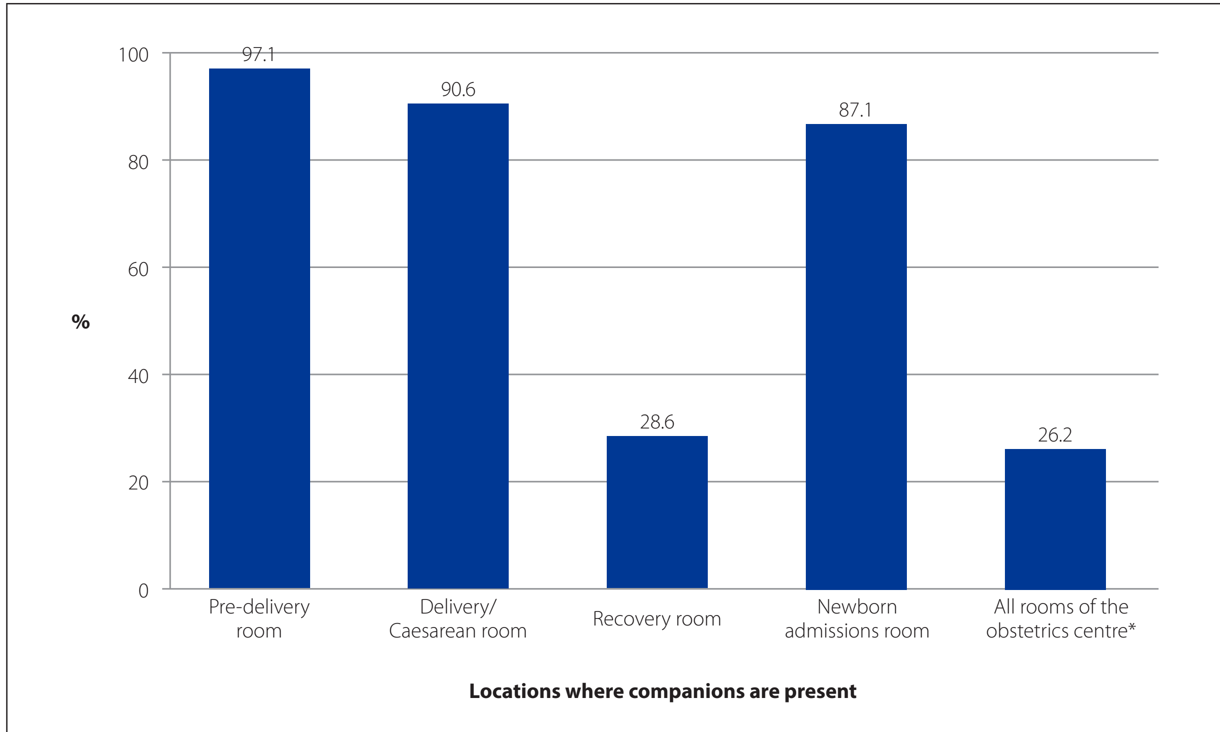

Figure 1 – Prevalence of companions by room of the obstetrics centre. HCPA, Porto Alegre/RS, 2012

*Pre-delivery, Delivery/C-section, Recovery and Newborn admissions rooms
Source: Research data, 2012.

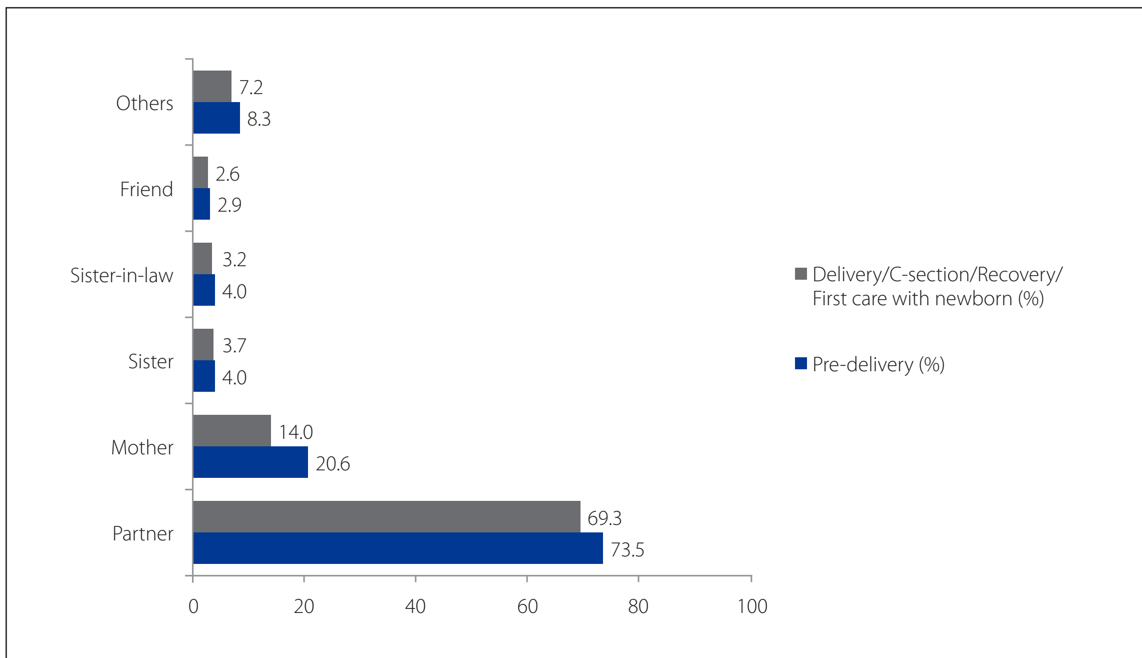

Figure 2 – Type of bond between the companions and the women in the pre-delivery, delivery, recovery and newborn admissions rooms. Porto Alegre/RS, 2012

* The total number of companions during labour does not correspond to 100%, since a recent mother could have switched companion during the parturition process, although this is not foreseen.
Source: Research data, 2012.

Table 2 – Reasons provided by the women (n = 244) for the absence of their companions in the recovery room. Porto Alegre/RS, 2012

Reasons	(n)	(%)
Not allowed	141	57.8
Companion did not want to stay	63	25.8
Companion stayed with the newborn in the admissions room and/or hospital neonatal unit	19	7.8
Companion was unaware they he/she could stay	12	4.9
Inadequate physical space	7	2.9
Women's choice	1	0.4
Team request	1	0.4
Total	**244**	**100**

Source: Research data, 2012.

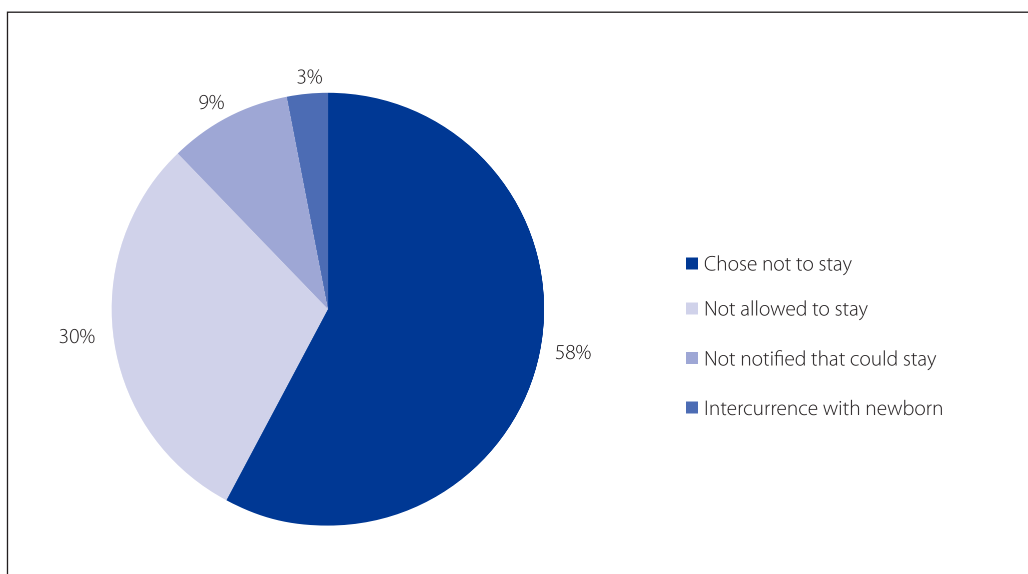

Figure 3 – Reasons provided by the women (n = 33) for the absence of their companions in the newborn admissions room. Porto Alegre/RS, 2012

Source: Research data, 2012.

and postpartum in the obstetrics centre, only 26.2% of the companions stayed with the women, which is a little higher than the finding of a national study[15]. In Brazil, 75.5% of women have a companion at some point during labour and only 18.8% of women benefitted from the continuous presence of their companions during the entire admission period, including at the inpatient obstetrics unit[15].

It is important to stress that this was not always the case at the institution in which the research took place. A qualitative investigative study on the '80s and '90s found that the permanence of companions depended on negotiation and approval of the health professionals; was restricted to the baby's father; and was not allowed in all the areas of the obstetrics centre. When the fathers were allowed to stay with the women, they would have to follow a series of criteria and guidelines established by the professionals, which made the participation of the fathers practically impossible[16]. In another study at the same institution conducted in 2009, companions were present in 85% of the 910 births at some point during the process of parturition[17].

In other institutions, the presence of companions is still restricted to certain areas of the obstetrics centre.

A study in health units of the state of Santa Catarina found that the presence of companions was not permitted in 33.9% of the delivery and caesarean rooms. During the first hours of the puerperium, the companions were asked to leave the recovery room in 22.1% of the studied health units[18].

With regard to the type of bond between the women and their companions, it was noted that most of the companions were present at all times, in the pre-delivery room, in the delivery room, in the recovery room and in the newborn admissions room. In a similar study conducted at the same institution, the people the mothers chose to accompany them in the delivery room were mostly the partners or fathers of the babies (81%), followed by the mother's mother (8%). Other companions the women mentioned were sister and sister-in-law[17]. Similar results were found in this study, since the companions of the women were generally their mothers or partners, regardless of the stage of parturition.

However, although the companions were present in the pre-delivery and delivery rooms for almost all of the sample, this did not occur so expressively in the recovery room. The collected data show a reduction of 70.5% and 68.4% for the presence of companions in the recovery room in relation to labour and delivery, respectively. However, a study in Santa Catarina showed that 81.4% of the companions were present in the recovery room when the woman had vaginal birth and 68.4% were present when they were submitted to caesareansection[18]. When questioned about the "reasons for not having a companion in the recovery room", more than 50% of the mothers answered "not allowed by the health professional". This is troubling, since the law guarantees the presence of a companion chosen by the women for the entire parturition process. The "not allowed" on the part of health professionals obstructs the right of the women to have a companion, and may be justified by the ignorance of these professionals of the law or their erroneous interpretation of the law and concerns regarding the change in routine. A study found that the attitude and the behaviour of the healthcare professionals in the hospital environment have a significant impact on the experiences of women in the process of parturition[19].

The "inadequate physical space" identified by some women as a justification for the non-permanence of the companions in the recovery room is consistent with reality, since these rooms are too small and lack the required privacy for the presence of companions. In order to provide a model of care that respects the privacy, dignity and autonomy of women in a welcoming and comfortable environment that allows the presence of companions, the spaces must be organised to create environments that favour this model[5].

In spite of these limitations, these justifications cannot prevent women from exercising their right to a companion, even when the companions choose not to remain, as mentioned by some women. Regardless of the local conditions, this should be a decision of the women and their companions, including in the case of permanence in the pre-delivery room, delivery room and newborn admissions room, and should not be an arbitrary decision of the health professionals.

With regard to the presence of the companion in the newborn admissions room, there was a drop of 9.8% and 3.9% in relation to the prepartum and postpartum, respectively.

In this study, most of the companions were the partners (69.3%) of these women and presumably the fathers of the babies. Even if the fathers only participate by overseeing the care of the newborn, this would be their first opportunity to effectively interact with their children, which could help strengthen the father-child bond. It should be noted that this model of care for the newborns is not suitable because it separates the baby from its mother. Ideally, in the case of mothers in good health and newborns with a good vitality at birth, the newborn should be directly placed with the mother for skin-to-skin contact and should not be removed from the room where the mother and her companion are for the routine procedures of admission, as established by Ordinance No. 371 of May 7, 2014, that stipulates guidelines for organising comprehensive and humanised care for newborns in the Unified Health System (SUS)[20].

CONCLUSIONS

In recent decades, there have been advancements in Brazil with respect to the model of care provided to mothers and their newborn babies based on the efforts to qualify care of social organisations, health professionals and the women themselves. The Ministry of Health has also played a key role in the implementation of measures that observe practices based on scientific evidence and involve the process of being born in Brazil, especially the presence of companions chosen by women during labour, delivery and the postpartum.

Prenatal care is considered the ideal moment to notify women of this right. Consequently, the health professionals who conduct the consultations and/or educational groups are responsible for advising the women on this and other issues related to the process of parturition.

Another issue was the absence of the nurses during the prenatal consultations, which leads to the conclusion that the nurses are not present in this area although they are qualified to perform the habitual risk prenatal care.

It is also important to stress the role of nurses in educational and preventive matters. Their contributions help empower women and increase their awareness in relation to pregnancy, labour and birth, with the consequent improvements to their health and the reduction of child and maternal morbidity and mortality, all of which are part of the Millennium Development Goals.

The presence of companions during the entire process of labour and birth was reportedly low in this study. Similarly, in terms of specific areas of the obstetrics centres, there was a significant reduction of companions in the recovery room. These findings reveal the importance of investing in ambience improvements and education of the health team in order to promote and encourage the presence of companions.

Finally, the presence of companions in the newborn admissions room to oversee the first care procedures was significant. In the Brazilian scenario, there are no records of studies that address the presence of companions during early prenatal care at the obstetrics centre, which signals the need for further studies on this important subject that is part of the process of birth.

In this study, some limitations must be considered. The first limitation refers to the sample, which was mostly composed of women from the capital city of Rio Grande do Sul who received care at the university hospital and may therefore not reflect the real situation of other maternity hospitals in the country. The second limitation that this study does not question the justifications of the companions for not being present in the pre-delivery and delivery rooms, which could support the implementation of improvements.

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