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UNFAVORABLE INSTITUTIONAL CONDITIONS TO THE PRESENCE OF THE
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RESEARCH

UNFAVORABLE INSTITUTIONAL CONDITIONS TO THE PRESENCE OF THE CAREGIVER: THE VIEWPOINT OF NURSES
CONDIÇÕES INSTITUCIONAIS DESFAVORÁVEIS À PRESENÇA DO ACOMPANHANTE: A VISÃO DOS ENFERMEIROS*
CONDICIONES INSTITUCIONALES DESFAVORABLES A LA PRESENCIA DE LO ACOMPAÑANTE: LA VISIÓN DE LOS ENFERMEROS
Pedro Bernardino da Costa Júnior¹, Isaiane da Silva Carvalho², Janile Bernardo Pereira de Oliveira Macedo³

ABSTRACT

Objective: To understand the difficulties found by nurses working in maternities in relation to the presence of the caregiver during the childbirth process. **Method:** We have performed semi-structured interviews with 12 nurses working in the care of the parturient in a maternity. The data analysis was conducted by means of the Bardin's Content Analysis Method. **Results:** We have identified the category *Institutional aspects related to the presence of the caregiver*, by presenting aspects related to the institutional reality, which hinder the warranty of the presence of the caregiver during the childbirth period of the woman. **Conclusion:** The lack of support from the administrative instances, physical structure and inadequate resistance from professionals were the most cited points as hindrances to the occurrence of the monitored labor. Nevertheless, it becomes necessary to seek ways to overcome these barriers and ensure the achieved right. **Descriptors:** Nursing, Childbirth, Patients' caregivers.

RESUMO

Objetivo: Compreender as dificuldades encontradas por enfermeiros que atuam em maternidades, quanto à garantia da presença do acompanhante durante o parto. **Método:** Foram realizadas entrevistas semiestruturadas com 12 enfermeiros atuantes na assistência à parturiente em uma maternidade. A análise de dados se deu pelo método da Análise de Conteúdo de Bardin. **Resultados:** Identificou-se a categoria Aspectos institucionais relacionados à presença do acompanhante, apresentando os aspectos relacionados à realidade institucional que dificultam a garantia da presença do acompanhante no período parturitivo. **Conclusão:** A falta de apoio das instâncias administrativas quanto à implementação da lei, a estrutura física inadequada e a resistência por parte dos profissionais foram os pontos mais citados como empecilhos à ocorrência do parto acompanhado. No entanto, faz-se necessário buscar maneiras de transpor essas barreiras e garantir o direito conquistado. **Descritores:** Enfermagem, Parto, Acompanhantes de pacientes.

RESUMEN

Objetivo: Comprender las dificultades enfrentadas por los enfermeros que trabajan en maternidades, para garantizar la presencia de un acompañante durante el parto. **Método:** Se realizó entrevistas semiestructuradas con 12 enfermeros que trabajan en la atención a mujeres durante el parto en una maternidad. El análisis de datos se realizó mediante el método de Análisis de Contenido de Bardin. **Resultados:** Se identificó la categoría aspectos institucionales relacionados con la presencia del acompañante, presentando los aspectos relacionados con la realidad institucional que hacen difícil garantizar la presencia de un acompañante durante el parto. **Conclusión:** La falta de apoyo de los órganos administrativos en la aplicación de la ley, la estructura física inadecuada y la resistencia por parte de los profesionales fueron los puntos más citados como obstáculos a la ocurrencia del parto acompañado. No obstante, es necesario buscar formas de superar estos obstáculos y asegurar el derecho conquistado. **Descriptores:** Enfermería, Parto, Acompañantes de los pacientes.

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INTRODUCTION

Over time, the childbirth went through an institutionalization process, which has resulted in several changes in the care model towards the birth, such as the replacement of home environment by the hospital scope, as well as the replacement of the monitoring of the midwife by the medical professional follow-up. The ancient female-centered care model gave rise to a male-centered model, usually, marked by neglecting the woman’s actual needs.¹

This care model was characterized by the early hospitalization of the customer, which remained alone throughout the labor, given that she was not adequately informed about the procedures to which it would be subjected, in addition to having her privacy invaded and not have autonomy to choose certain actions. Such situations increased the doubts and fears that appeared and/or were fostered during the pregnancy.²

By opposing these precepts, studies conducted in several countries have shown numerous benefits associated with the presence of the caregiver during the childbirth process, such as reducing the rate of cesarean section, oxytocin usage, labor duration, analgesia for relieving pain and perineal trauma, besides perceiving increased maternal satisfaction with the childbirth experience, among others.³

From this perspective, The Law nº 11.108, dated of April 7th, 2005, was approved and sanctioned in Brazil, which obliges the healthcare services of the Brazilian Unified Health System (SUS), from its own network or from associated others, to allow all pregnant women to have a caregiver of their choice in the antenatal, labor and immediate postpartum periods.⁴

Nonetheless, in many situations, we cannot see the fulfillment of the law in force.

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There is a strong resistance to the presence of the caregiver, especially caused by the technocratic care model, which contributed to dehumanize the childbirth and to move away the family from this happening, by turning the childbirth into a medical-hospital event, shaped by institutional routines.⁵

In the proposal of care humanization of the childbirth, we could cite the nurse as a professional recognized by the Brazilian Ministry of Health (MS), able to hold a holistic training and qualified to act in humanized way in caring of the parturient woman within the several care environments.⁶ Thus, it becomes necessary that such professionals are heard and included in the discussions on family care during the childbirth process.

Therefore, whereas the right to the presence of the caregiver, guaranteed by law since 2005, is often breached by the healthcare institutions, and the nurse is admittedly an important subject in the proposal of care humanization, this study asks: What are the difficulties encountered by nurses to assure the presence of the caregiver during the childbirth period of the woman?

This study aimed at understanding the difficulties encountered by nurses working in maternities in relation to the warranty of the presence of the caregiver during the childbirth period of the woman.

It is noteworthy that this paper was written based on the monograph entitled “Law 11.108/2005: challenges and perspectives for its implementation from the viewpoint of the nursing professional”, presented to the Faculty of Educational Excellence of Rio Grande do Norte (FATERN), which is located in the city of Natal, Rio Grande do Norte State (RN), in 2011.

METHODOLOGY

It is descriptive and exploratory study, with a qualitative approach. It was developed in a public maternity, located in the Rio Grande do Norte State, where the obstetric and neonatal care is provided by nurses, nursing technicians, obstetricians, gynecologists, neonatologists, pediatricians, pharmacists, social workers and psychologists.

The population consisted of 12 nurses who worked to provide care to the pregnant women during the childbirth period. They were selected through purposeful sampling. With a view to better directing the data collection, we have considered the following inclusion criteria: the subject should be graduated in Nursing and being working at the motherhood under study for at least 06 months. The final sample size was defined by the saturation process, in which the data collection goes through until the time when no additional information can be obtained, by reaching the redundancy.⁷

The study, because of its nature of human research, followed the precepts of the Resolution nº 196/96 of the Brazilian National Health Council (CNS/MS), which establishes the rules and guidelines that regulate the researches involving human beings.⁸

We have requested the maternity's director, through official letter, to sign a consent letter authorizing the development of this research in the above mentioned institution. In possession of the authorization, the project was sent to the Ethics Research Committee from the Federal University of Rio Grande do Norte (CEP /UFRN), with sights for getting consideration and issuance of the respective opinion, which was favorable and was given by means of the code 175/2011.

The interviews were conducted between the months of June and July 2011, by using a semi-structured interview script. The tool was comprised of two parts; the first consisted of the sociodemographic characterization of the participants, and the second was composed by the guiding question of the study: In your viewpoint, what are the factors that hinder the presence of the caregiver during the childbirth period of the woman?

The data treatment and analysis occurred through the Bardin's Content Analysis process. This method is comprised of three stages to be covered, namely: Pre-analysis, Material exploration; and Results treatment, inference and interpretation.⁹

RESULTS AND DISCUSSION

As a way to reach a better understanding of the subjects, we produced a sociodemographic characterization thereof. The study participants were 12 nurses who provided direct care to the women during their childbirth period. To ensure their anonymity, their names were replaced with words that represent the childbirth moment. Of these, 11 were female. Concerning the age group, the ages ranged between 24 and 51 years, with a prevalence of the range between 31 and 40 years (six subjects), followed by the range between 21 and 30 years (three subjects), a fact that reveals a relatively young profile of professionals in the Obstetrics field.

Regarding the year of completion of the graduation, this happened between 1986 and 2009, being that the majority of respondents completed their college course in the last ten years, a period in which there have been major changes in the Nursing field. Beyond the graduation, 10 subjects had finished a lato sensu post-graduation course, six in the Obstetrics field,

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two in specialization on Intensive Care Unit (ICU) and two in Public Health. It is considered that the professional qualification is a key factor for the improvement of the quality of the provided care.

Regarding the working time in the institution, only four of the professionals worked for less than 3 years. Furthermore, 11 surveyed nurses had two or three employment relationships, including teaching activities, Family Health Strategies (ESF) and other hospital sectors.

The application of the content analysis process towards the subjects' speeches allowed us to create the category *Institutional aspects related to the presence of the caregiver*. This category shows the aspects related to the institutional reality, which hinders the warranty of the presence of the caregiver for the woman on her labor period. The points highlighted by the subjects allowed us to divide this category into three subcategories, which will be discussed below.

Administrative aspects

The participants highlighted that the lack of support from the administrative instances in relation to the monitored childbirth ends up hindering this practice, since there is not a steady institutional standard or routine that stimulates it. These ideas are realized in the hereinafter discourse:

[...] I see that [...] the monitoring criterion, is an administrative decision, which comes from the managers, advocates this situation, where one establishes for the pregnant woman, whether she is multiparous or primiparous [...] having someone who is abreast of her [...] (Affection)
[...] I think the maternity should also [...] support [...], the direction too, technical, administrative and general direction, everything. I think all this aforementioned things compose a set [...] (Accomplishment)

In this regard, it should be perceived that the institution is responsible for standardizing the

actions or legitimizing the routines developed by professionals over time. These professionals, even though they have the same technical skill and being legally autonomous to meet the parturient, are often restrained from this right or duty, due to an institutional routine in which they accept or, even, require a passive stance in the guidance of decisions and actions in caring of the public.¹⁰

Thus, it is understandable the need for awareness of hospital managers to humanize and to build a management model that focuses on the ideals of this process, they are: an organizational culture based on respect, solidarity, development of autonomy and citizenship of subjects involved and of the users.¹¹

A project for including the caregiver at the childbirth time should proceed from directors of healthcare institutions and integrate a broader project of care humanization aimed at supporting the labor procedures and the childbirth itself. Isolated initiatives of professionals might be insufficient, especially when the main concern is to fulfill the requirements that the institution imposes.¹²

Structural aspects

The unsuitable institutional physical structure was one of the main factors emphasized by professionals as an obstacle to the presence of the caregiver. This structural deficiency is related both to the small space of the obstetric services installations to accommodate patients and caregivers and to the lack of material resources, such as the absence of seating to accommodate the person who intends to follow-up the parturient. This reality is reported in the following excerpts:

The issue of the physical structure [...] today, we haven't a structure for companions [...] (Satisfaction)
[...] the space is too small, it doesn't have enough seats for companions, even in the delivery room, it's also very small [...] (Pleasure)

The companion who comes here, he is willing to spend the night sitting, awake or, perhaps, put the head on the patient's bed headboard with sights to sleep. (Emotion)

According to the Brazilian Ministry of Health, there are few hospitals that have, in their obstetric services, the minimum and suitable conditions and installations to allow the presence of a caregiver to the pregnant woman in labor in the SUS network.¹³ This reality goes against the PHPN precepts, which recommend that the healthcare units should receive the woman, her family members and the newborn (NB) with dignity, in an ethical and supportive way, thus creating a welcoming environment and by instituting routines that break with the traditional model of isolation imposed on the woman.¹⁴

Some reports showed that, sometimes, the presence of many people in the delivery room is an aggravating factor for the little existing space. The delivery room needs to contain professionals from several academic backgrounds who attend to the parturient and the newborn, academic students who conduct their traineeships and the patients themselves. Thus, one ends up judging infeasible to insert one more person in the room at stake, as it is stated by the respondents below:

When you have a woman with you there, you have the medical staff, you have a nurse walking around, you have the pediatrician, you have a coach who're at your side, suddenly, one medical student or one nursing student arrives there, understand? The room becomes small, and the patient's privacy, how does it work? (Joy)
[...] We have small delivery rooms [...] and there isn't condition to have a companion in all the rooms [...]. Because you have to have medical care, nursing care and nursing technician care, during the process [...] (Tenderness)

This care model is a reflection of the institutionalization and medicalization processes of the childbirth moment, through which the labor J. res.: fundam. care. online 2013. out./dez. 5(4):671-80

experience, once predominantly homely, incorporates practices in which the use of hard technologies is prevalent. Thus, the childbirth leaves its subjective, private and family sphere to become a fact essentially medical/technical and hospital-centered.¹⁵

It should be observed that the medicalization of the childbirth has turned several technical procedures, over time, into routine executions, such as medication administration, anesthesia, episiotomy, episiorrhaphy, among others, by justifying the need for this cluster of professionals around the patient, thereby giving an almost pathological aspect to the childbirth.

Other interviewees made reference to the great demand for care in the maternity, which generates overcrowding and further jeopardizes the physical space. This is due to the fact of the institution in question is located in a city which is reference in the region, thus encouraging the smaller towns in its surroundings to search for its service. The following speeches illustrate such a situation:

Another issue is the overcrowding of the maternity [...] since several municipalities are associated to the city of Parnamirim, in order to send the mothers for us. And, in this case, as they are many, usually, we need [...] chairs in the hallway [...] the overcrowding makes it difficult [...] (Life)
[...] we have a very large agreement. So, as I ever said, well, I've already got a duty with twenty-four patients admitted here [...] from the O.C., Obstetric Center. (Emotion)

Given these considerations, it should be noted that the imposition of managerial agreements from the SUS took place from the Basic Operational Norm dated of 1996 (NOB-96). From the negotiation of goals, it raises the combination of actions and responsibilities among the health managers, a process that began with actions developed on the individual healthcare scope, through the Agreed and Integrated Programming (PPI) and, subsequently, adding

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collective actions by means of the PPI -ECD (Epidemiology and Disease Control), later known as PPI-VS (Health Surveillance).¹⁶

Through the agreement system, it is common to realize municipal healthcare establishments or bodies receive users coming from other ones, given that the municipal healthcare systems have different levels of complexity and establish among themselves a reference/counter-reference process. This process takes place through negotiations conducted among the municipal managers.¹⁷

It is understood that the inter-municipal agreement is a way to improve the provision of healthcare services, by allowing the users to access the different levels of care. Nevertheless, this mechanism requires a proper planning, in order to prevent the disorganization in the institutions' demands, which leads to the overcrowding mentioned by the study subjects.

Professional aspects

Another point highlighted by nurses as a hindrance to the presence of the caregiver is related to the existing resistance, not only from their workmates, but also from other professionals of the healthcare staff who care of the parturient. The highlight was focused on the medical practitioner, which, in most cases, is responsible for deciding the participation or not of the caregiver, as the interviewees have expressed in the following speeches:

There is also the issue [...] the medical culture [...], there are some doctors who do not allow, they do not like. (Love)
Depending on the doctor, it occasionally permits [...] the husband watch the labor, or her mother, but not all doctors allow us to do it. (Emotion)
[...] it depends a lot on the doctor and of the duty too. Some doctors authorize, other ones do not authorize [...]
(Pleasure)

Moreover, in another study, there was an allusion to the fact that the medical desire is prevalent in the permissibility as to the caregiver. J. res.: fundam. care. online 2013. out./dez. 5(4):671-80

The authors noted that the monitoring was not allowed on all duties, because some practitioners accept it and others did not do the same. Of the 11 surveyed women, only three received assistance in the delivery room.¹⁰

It should be learned that this predominance of the medical desire refers to the medicalization process of the childbirth, through which the woman have lost her leading role at this time and had her choices curbed, among them the choice of having someone trusty at her side. In contrast, the doctor started to take decisions about the circumstances in which the childbirth should be elapsed.

Accordingly, the pregnant woman who chooses to have a caregiver will be at the mercy of the routine of the healthcare institution, and the caregiver, in turn, will be subject to the decisions of professionals who establish power relationships before the labor situation. Unfortunately, this is still the reality of the obstetric services in the Brazilian territory.¹⁸

The medical dominance was also reported by the research participants in relation to other professionals of the healthcare staff, according to the argumentations contained in the following statements:

[...] Nowadays, we always see this kind of situation; the doctor is the head within the hospital environment [...] (Pleasure)
[...] the doctor is the one who determines this situation, as leader of the duty and as head of the duty [...] I, as nurse, I will not interfere in the doctor's tasks; I won't find it necessary that a companion should enter and, next, he finds it necessary that nobody should enter; thus, this divergence would create an internal conflict. (Affection)

[...] Even if I release, but if we had a whole structure here, [...] And that I would release the patient with an companion to stay there in the pre-birth room, everything right, but, at the delivery time, I cannot do this; if the doctor who is monitoring the labor denies my request, I cannot force him, because it is already a thing [...] that is originated [...] from his training [...] (Emotion)

The aforementioned speeches clearly demonstrate the strong hierarchicalization that takes place within the healthcare staff, in which the doctor assumes the highest level of prestige, given that it is considered the *top*, *leader* or *boss*.

The doctors and nurses are two professional categories of extreme relevance in the implementation of activities in the hospital institutions, however, since that they act in an interdependent manner, by forming close bonds, have a strong potential to develop inter-professional conflicts. These authors also stated that the construction of the dichotomy contained in the relationship between these actors refers to the historical attributes of each one of them, as well as the form of relationships of the social representations assigned to them.¹⁹

Since the Renaissance, the medical practice covered the care of the rich and noble citizens through which the doctor received high fees and honors. The Nursing, in turn, had its beginnings in the hands of unselfish and religious women who provided care to poor and sick subjects. Nonetheless, it was a lay practice and that was not linked to the scientific knowledge.²⁰

The scientific basis of the Nursing, which boosted its professionalization, only emerged from the efforts of Florence Nightingale in the Crimean War, in 1854, when, along with 38 women (Anglican and Catholic), organized a hospital to care of the 4.000 soldiers participating in the battlefield.²¹

It is understood that such differences in the origins of each profession, given that the Medicine has consolidated its scientific foundations for longer than the Nursing and be related to a high social status and a considerable economic power, help to understand the existing hierarchy between them.

It is considered that the doctor and the nurse are irreplaceable professionals in healthcare
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scope and that have different functions in providing care, but such actions are complementary to achieve the ultimate goal of their efforts - the patient's health. Thus, it is essential that there is dialogue and respect between these two work fields, so that the teamwork can satisfactorily flow.

Another topic pointed out by survey respondents, with regard to the professional aspects, was their role, as nurses, for the allowance of this monitored childbirth process, by highlighting their importance as a facilitator agents in this situation and as preparers of the parturient and the caregiver for the birth moment. The speeches below address the topic:

The conduct of the nurse is extremely necessary for this moment. [...] He must be prepared to conduct that junction, that duplicity of the companion with [...] the patient, with the mother. If he knows to correctly conduct, he does, if not [...] (Happiness)

I think that the nursing professional from the primary care could already begin its performance in this step of orientation [...] Along with the companion and pregnant women, working together and explaining everything, guiding, leading in the best possible way, so that when he arrived here [...] already have at least a notion [...] a calmness [...] (Tenderness)

In this context, the study showed that the nursing professional has a pretty relevant role in the proposal and maintenance of projects that aim at including the caregiver in the childbirth period, since this professional works in the preparation of the companion, so that this person can play an active role during the labor process. The authors also emphasize the nurse's role as "a facilitator and promoter agent of the understanding of the needs highlighted throughout the care".^{12:79}

In another developed work, the nurses also classified themselves as important subjects of the process towards the allowance of the childbirth with a caregiver. The professionals reported that, although there are many barriers to this reality,

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believe make their maximum efforts to implement it, by offering support, by guiding the customer and, whenever can help, by facilitating the presence of the caregiver.²².

CONCLUSION

Given the assessment of the subjects' speeches and the analysis of the specialized literature on this issue, it was possible to identify that the presence of the caregiver, although it is not a distant reality, still is hampered by many obstacles, among which the institutional aspects established in the healthcare services are highlighted.

The lack of support from the administrative instances, physical structure and inadequate resistance from professionals were the most cited points as hindrances to the occurrence of the monitored labor. Nevertheless, it becomes necessary to seek ways to overcome these barriers and guarantee the right that parturients have won since 2005, in order to rescue the subjective and pleasurable nature of the childbirth.

Given the focus on the issue of unsuitable physical structure to accommodate the caregiver, whether by the reduced space or by the commitment of the privacy of other parturients, the installation of partitions among the hospital beds contained in the pre-birth rooms and in the collective accommodation center emerges as a possibility to ease these difficulties.

In addition, the promotion of continuing education for the healthcare professionals, by informing them and sensitizing them regarding the relevance of the presence of the caregiver and the benefits resulting from this practice, appears as a way to undo preconceived ideas and to make them agents and stakeholders in ensuring the women's rights.

Moreover, whereas the importance of the scientific production to consolidate the J. res.: fundam. care. online 2013. out./dez. 5(4):671-80

theoretical and practical foundations related to the issue, as well as the lack of studies related to the professionals' perception about the caregiver, it is crucial that further discussions are developed, by contemplating mechanisms for inserting it and overcome the found challenges against its participation during the childbirth period of the woman.

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