Obstetric nursing and its interface with the brazilian obstetric model

A enfermagem obstétrica e sua interface com o modelo obstétrico brasileiro

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RESUMO

Objetiva-se analisar a inserção das enfermeiras obstétricas no cenário assistencial de uma maternidade de ensino no Rio de Janeiro. Estudo descritivo, exploratório, de natureza qualitativa, realizado com 15 profissionais de saúde e gestores em uma maternidade de ensino no município de Petrópolis, Estado do Rio de Janeiro, no período de dezembro de 2016 à março de 2017.A coleta de dados ocorreu por meio de entrevistas semiestruturada, e posteriormente foram transcritas e submetidas à análise de conteúdo na modalidade temática. Observou-se que a inserção das enfermeiras obstetras ocorreu pelo cumprimento de determinações da rede cegonha; para a transformação de um modelo biomédico para um humanizado na atenção ao parto e nascimento. Conclui-se que a estratégia da rede cegonha permitiu a inserção das enfermeiras, para se promover uma mudança de modelo, e trazer na sua prática a humanização do cuidado.

Palavras-chave: Serviços de saúde materno-infantil; Saúde da mulher; Parto; Parto humanizado; Enfermeiras obstétricas.

ABSTRACT

The objective of this study was to analyze the insertion of obstetric nurses into the care setting of a teaching maternity hospital in Rio de Janeiro.A descriptive, exploratory study of a qualitative nature, carried out with 15 health professionals and managers in a teaching maternity hospital in the city of Petrópolis, State of Rio de Janeiro, from December 2016 to March 2017. Data collection was by semi-structured interviews, and were subsequently transcribed and submitted to content analysis in the thematic modality. It was observed that the insertion of the obstetrical nurses occurred by the fulfillment of determinations of the stork network; for the transformation of a biomedical model to a humanized one in the attention to childbirth and birth. It is concluded that the strategy of the stork network allowed the insertion of nurses, to promote a change of model, and to bring in their practice the humanization of care.

Keywords: Maternal-child health services;Women´s health; Parturition; Humanizing delivrey; Nurse Midwives.

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INTRODUCTION

The predominant and traditional model of obstetric care in Brazil is directed to the obstetrician and hospital care,[1] focusing on the sovereignty of the medical conducts used to the pathological aspect of gestation and childbirth, culminating in the interventions centered on the technological model of childbirth.[2]

This model has the idea of considering the body of the woman as a machine, and within this ideology, brings the thought of being manipulated and repaired, by a trained professional, the doctor, and by this current of thought that the model has the focus on intervention of the woman's body.[2]

With the mobilization of public service users, health professionals began to question the many practices used in the context of childbirth and birth in the mid-1980s, such as the excess of medicalization, episiotomy, and the high rates of elective cesarean sections in the parents. Thus, the questioning of the loss of the autonomy of the woman, who began to undergo unnecessary procedures, passing to the doctor gaining prominence and the main protagonist of the process of birth,[3] for a change of model, and began to bring the process of the model of humanization.

Thus, the insertion of good practices in normal childbirth, based on the humanized model, which was established by the World Health Organization in 1985, began the process of deconstruction of the technological model.[4] In this sense, these promoted obstetric behaviors the World Health Organization proposed evidence-based assistance based on the classification of obstetrical procedures in normal birth according to the criteria of utility, efficacy and risk. These recommendations gave rise to the categories of practice in the provision of standard childbirth: category A - practices, demonstrably, useful and to be encouraged; category B - clearly harmful or ineffective practices which must be eliminated; category C - practices where there is no evidence to support its recommendation and should be used cautiously until further research clarifies the issue; category D - practices that are often used inappropriately.[1] Thus, even with the recommendations women in Brazil are still exposed unnecessary interventions.[5]

Thus, the Ministry of Health began the incentive and the incorporation of the obstetric nurse in the hospital teams and bets on its contribution to reduce the use of interventions and unnecessary caesareans, which characterize the obstetric care in the Country.[1] It is worth noting with the incorporation of the obstetric nurse in some public maternity hospitals in the city of Rio de Janeiro, from 1998, was the first initiative taken by governmental agencies in this direction. The organization of care in the humanized model is an exception, with the participation of this professional in the estimated national health care in 10.0% to 15.0%.[1] And the Stork Network, through Administrative Rule no. June 2011 came to boost their insertion and training of human resources for humanized care at birth and birth.

Thus, there is a need to understand the process of insertion of obstetrical nurses based on the demand of health professionals and managers and their interlocution with the strategy of the Stork Network in accordance with the principles of the Unified Health System, based on coordination of Women's Health, which deals with the effectiveness of the humanization of care for childbirth and birth,[6] comprising through investigations the multidimensional aspects that involve the experience of childbirth and obstetric practices in their physical, emotional and social aspects.

Thus, the study aims to: Analyze the insertion of obstetric nurses into the care setting of a teaching maternity hospital in Rio de Janeiro.

METHOD

A descriptive, exploratory study of a qualitative nature carried out in the maternity hospital of the Alcides Carneiro Teaching Hospital, located in the city of Petrópolis, state of Rio de Janeiro, Brazil, from December 2016 to March 2017 with 15 managers and health professionals who participated in the insertion of obstetric nurses in the teaching hospital. The exclusion criterion corresponded to health professionals and managers who were not in their functions, and those who are no longer a collaborator of the hospital unit.

A semi-structured interview was conducted on the insertion of obstetrical nurses, which took place in a private environment, thus guaranteeing the participant's privacy. The interviews ceased through the data saturation process. In order to ensure the confidentiality and anonymity of the participants' testimony, they were identified as' Interviewee 'and received a sequential alphanumeric code (E1, E2,... E15).

The recording unit was used based on the theme as a strategy for organizing the content of interviews. For that, different colors were selected, with the purpose of identifying each unit and grouping them, thus allowing an overview of the theme. The following registration units originated: Contractualization of the Stork Network: a policy that promotes changes in the assistance model to Parto and Nascimento; The induction of change in the assistance model from the strategy Stork Network; The Stork Network as inductor of the insertion of obstetrical nurses in the work process of the Teaching Hospital. These registry units supported the construction of the thematic nucleus: The insertion of Obstetric Nursing in the setting of the Alcides Carneiro Teaching Hospital, originating the thematic unit: Expressions of health pro-

fessionals and managers on the Stork Network strategy and the induction in the change of the model of delivery and birth care. Thus, the thematic category formed in the analysis, namely: The stork network as a transitional political framework of the obstetric model and the interface with obstetric nursing.

The research was approved by the Research Ethics Committee of Hospital Universitário Antônio Pedro, Federal University of Fluminense, under protocol no. 1,839,020 / 2016, pursuant to Resolution 466/2012 of the National Health Council.[8] participation, all participants signed the Informed Consent Term.

RESULTS

The stork network as the transitional political framework of the obstetric model and the interface with obstetric nursing

For the participants, the insertion of the obstetric nurses in the maternity occurred to fulfill the determinations of the program of the Stork Network as indicated in the following statements:

> *"I'll say basically what I know, it was because of the Stork Network in the Petrópolis municipality, that's why a new hire is needed"* (E2)
>
> *"The contracting occurred due to a requirement of the implementation of the Stork Network, which has a requirement of contracting obstetrical nurses in the classification of risk, not only in the classification, for now we only have in the classification, but for you to start with the first project step is to have obstetric nurses inside the maternity ward"* (E4)
>
> *"The Secretariat at the time informed that it was enabled for us to receive resources from the Stork Network, which later became incorporated into the financial ceiling of the municipality and there the need to hire obstetrical nurses was to comply with these items to make the hospital case linked to this issue of Stork Network, of these nurses with specialization in obstetrics, was to actually attend to the parameterization of the Ministry."* (E9)

Participants pointed to the importance of obstetric nursing in the transformation in the model of attention to childbirth and birth:

> *"Our goal is not only to serve the stork network, we wanted to insert a professional in the maternity that began to give maternity that face of humanized service, of welcoming, to treat the pregnant woman not as sick, but as that arrives to gain a gift, winning a child is a gift, it is the greatest gift, for sure."* (E1)
>
> *"The main objective is that among the pillars of the Stork Network is required to have obstetric nurses, why? Because this obstetrical nurse will have a holistic look, to work mother, baby, puerperal in a more humanized way, more contact and everything that involves the pillars of the Stork Network that there is already a lot involved, not only childbirth is the nurses working in every corner."* (E7)
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> *"Without doubt a better care for pregnant women and parturients, better health condition, a more welcoming environment, the right to know as a mother, to know the delivery, to understand the process that no one explains, who explains is the nursing without doubt, someone to stay with they are there to give support, and someone is technically prepared to deliver a first-line birth."* (E15)

The implantation of a humanized model, and the possibility for a change of the hegemonic model in the attention to the childbirth and birth, with the insertion of the obstetric nursing is necessary, through the Stork Network,that according to the participants have obstacles for its execution in the totality in obstetric nursing conducts, according to the statements:

> *"We went first to risk classification. The initial proposal was to fill the vacancies in the classification of risk, and in a second moment to leave for obstetrician nurse acting in the assistance. Here we have worked for many years without the insertion of the nurse, we think it wiser to go in stages. First adapt all the medical professionals with the obstetric screening, in the practices of the classification of risk, in a second moment to put a nurse assistencialista."* (E1)
>
> *"I know that obstetrical nurses not only have to make admission, but also follow the whole process and she give birth, and we do not have it here, they're just in admission screening, and we have to make a lot of progress in this. Yes, because they are only doing the screening, we have to walk to the delivery and get the delivery, I confess that is my private opinion, because the nurse in the (there is at present a decrease in the tone of the conversation, to speak lower and say that he will talk because he knows to be secretive) manages to make the delivery more humanized."* (E2)
>
> *"At that moment we started with the risk classification, so their entry was through the implementation of the Stork Network. At the time we hired 4 obstetrical nurses to work on a 24x7 shift and are here on admission and observation that is part of this block."* (E9)

Another aspect to be highlighted refers to the aspect of medical hegemony, because when asked about the work process of obstetrical nurses, the participants revealed questions that demonstrated that the medical class, loaded with medical practices, becomes the main impediment for the performance of obstetric behaviors performed by nurses, according to the following statements:

> *"Literally, humanizing nursing care, taking the focus of that work that the doctor has the role of healing, that*

is not his role within the maternity, but as our maternity is inserted within a general hospital this view gets extremely contaminated." (E1)

"Because it was a very medical-oriented hospital, we initially decided to put the nurses as an obstetric risk classifier and host, and not to place the obstetric nurses directly in the delivery room, it was like we were making an adjustment in the service, , we faced some problems, because initially the nurses were called support or supporters, so their talk was: now we have some support, so it will help our work a little." (E9)

"I see today that the greatest difficulty is with medicine itself, because we have very old planters who do practices that do not contemplate the Stork Network and this is a barrier, and even complicated to talk about it, because the rules that the Stork Network he prays that the birth is natural, if the birth is natural he can not have induction with medication, which is what we see routinely, because the speech is the following, we will put to be born, so let's put to birth means to accelerate this physiological process. And another thing is also the submission of the patient by the professional." (E10)

On the other hand, it is understood that changing a predominant model impregnated with health training is not an easy task, especially if there is no dialogue between the parties involved. In some testimonies, the way in which these health professionals were inserted in the service is highlighted, having a negative impact on the acceptance of an integral part of the obstetric team, as in the following statements:

"They were hired and we set up an ambiance with them all over the hospital, they went through Neo, lodging, presented to the technicians and the admission, we presented to the nursing staff and the medical chief of the medical team of obstetrics and in the course of their shifts they were presented the other teams. We never had a meeting of nursing staff, obstetric nursing, nursing technicians, doctors. We did not have that feedback. Soon who we arrived, no one came and introduced. Look, this is the medical chief responsible for obstetrics, this is the obstetrical nursing team that will compose the team. That was not so much that we had some relationship problems and understandings, because that feedback we did not have." (E4)

"The medical team was not ready to receive these obstetrical nurses, and any problem that was going to be a scandal, so what I wanted to do first: an atmosphere, that was my initial, of those nurses doing risk classification and reception of these patients, that these nurses integrated into the team of obstetricians until this formed bonds of professional confidence." (E8)

"The picture was not complete and she needed someone who had experience and I already worked there with the protocol of MS, the same protocol that she used here and then I was indicated and I already came with the work card, so not it was a very selective process, it was an interview: look you will work here, the salary is this and the job is the risk classification and period. There was no training, the coordinator told me that there was no time to train, that was to use the same protocol used in the maternity of Rio." (E10)

It is undeniable that in the current context, advances have been made in some regions of the country, such as in metropolitan areas, where some maternity hospitals were privileged with the implantation of the humanized model through the incentives of the Stork Network, and managed to maintain quality in health actions and services:

"I made a technical visit in 2014 to" Sofia Feldman "in Belo Horizonte, Minas Gerais, as there was already this expectation of people being accredited by the Stork Network, at that time we went to meet to see what we could be modifying, getting organized, anticipating, when the Stork Network arrived. I saw, I saw there, a whole day, which is totally different from what we have here, the presence of the family, the movement of people within the maternity, although I know it is only maternity, but within a model totally humanized." (E4)

"I see good behavior of the obstetric nurse inside the maternity ward, I experience experiences in other places such as Fernandes Figueiras, we did some 5 years ago a visit to Sofia Feldman in Belo Horizonte and we see that when the team is integrated, everyone wins, wins the doctor, wins the nursing, wins the technical support staff and mainly wins the main character who is the mother and the baby." (E6)

"We are able and able to change places, for example I worked since I graduated in three places, in my residence in Mariska Ribeiro which is a municipal maternity of Rio de Janeiro, which is Rede Storey, and Cargonian Stork who made some modifications, in Fernando Magalhães who is also in RJ, who is also Carioca Stork, then two humanized models and the third here, there we have obstetric nurses inside the scene, acting in labor, because there it has autonomy for that." (E10)

DISCUSSION

The determination of the Stork Network in the insertion of obstetrical nurses to work in maternal and child health is related to the need to change the maternal care in the country, providing women with a humanized, holistic and integral care, asserting their rights to their autonomy and their personal values. It should be emphasized that the incorporation of obstetric nursing in the obstetric care model shows an assistance with lower rates of interventions with the woman, such as episioto-

my, oxytocin, cesarean section; and greater satisfaction of women in the care offered.[9]

To that end, the Federal Nursing Council (COFEN), with Resolution No. 0477/2015, which provides for obstetric nursing, establishes that among other activities that are exclusive to its professional practice, it is stated that it is incumbent upon the obstetric nurse, in addition to his / her legal duties, to care delivery without distraction, respecting the individuality of the parturient and prioritizing the use of non-invasive care technologies.[10] Thus, it shows that the performance of maternal health, nurses with obstetrical nursing specialty have the legal support for their performance, in their different actions advocated in the Stork Network, showing the need to expand care for women through the insertion of obstetrical nurses.

Thus, with the Stork Network, with the insertion of the obstetrician nurse, the Ministry of Health (MOH) promotes the qualification and qualification of health professionals, valuing nurses so that they can act in a humanized and quality of women and children by providing evidence through scientific evidence. These MS actions have been intensifying the training and specialization of professionals with this profile to act together with the strategy of the Stork Network.[11]

The analysis of the interviewees' testimonies showed that the valuation of humanized childbirth should be taken into account, since it increases women's autonomy and decision-making power in a less authoritarian relationship. In this context of normal birth attendance, it implies that the obstetrical nurses have a more solidary attitude between the professional and the woman for a good evolution in labor.

Humanized attention to childbirth refers to the need for a new look, understanding it as a truly human experience. Welcoming, listening, guiding and bonding are key aspects in caring for women. The concept of humanization involves attitudes, practices, behaviors and knowledge based on the healthy development of labor and birth processes, respecting individuality and valuing women. The perspective of the concept of humanization was adopted as proposed by the Prenatal and Birth Humanization Program (PHPN), which was constituted in 2000, in order to qualify prenatal care in terms of access and coverage, but also to improve attention to the parturitive and puerperal processes.[3]

It should be emphasized that the process of humanization occurs through an imposition of the Government Policy, which has the objective of reducing cesarean rates, lower rates of interventions and medicalization in childbirth, besides the implementation of practices such as: a warm environment, massages, the possibility of vertical births, pain management, promote skin-to-skin contact between mother and baby immediately after birth, stimulate breastfeeding in the first hour of life and follow the ten steps for protection, promotion and support to breastfeeding, in addition to the presence of the companion of the woman's choice.[12] Promoting a rupture of the model, and the obstetrical nurses are inserted in this context of change.

However, in the participants' statements, the obstacles to the implementation of all activities of obstetric nursing practices, advocated by the Stork Network, are highlighted, mainly in the issue of autonomy for childbirth and birth, since they are restricted in the function of reception and risk rating.

Thus, it is stated that practices harmful to childbirth still occur frequently with women, demonstrating the authoritarianism of health professionals, often used as a form of oppression of women's lack of knowledge about their sexual and reproductive rights, and are not respected their opinions and actions taken without their knowledge and consent.[12-13]

Despite all the regulations, the issue of competence and responsibility of obstetric nursing has been questioned. If on the one hand the medical norms determine the competence of the doctors, on the other, the obstetric nurse also has its attributions and competences to make the obstetric diagnosis, which is the confirmation of the labor of eutocic and the deviation to the dystocic delivery.[14] Showing their ability to act together with childbirth and birth, and when obstacles are created to exercise their skills, it shows mainly how the biomedical, technocratic system is inserted in the relationship in maternal care, hindering autonomy and also in the rupture of the health model, as a loss of market.

In these discourses, we observed that the predominant medical hegemony in the Brazilian scenario is a difficult factor in the change of the process of the insertion of the obstetrician nurse in the humanized model. It is observed that the predominant hegemonic model impairs the assistance with the woman, within what was expected to have as humanized care, overcoming the barriers of the medicalization of childbirth and medical hegemony.

It should be emphasized that the obstetric assistance in the collaborative model means the integration of the obstetric doctor and nurse, acting jointly for the quality of the assistance and for the satisfaction of the woman, obtaining the scientific evidence for the guarantee of women's rights.[1] The Collaborative Model is predominantly involved in the organization of obstetric care in industrialized countries, such as England, Germany, Scandinavia, New Zealand, Canada and Australia, in which it values the physiological process of women and reduces childbirth interventions such as insertion of the obstetrician nurse in the birth model.[15]

Although unequal relations of power mark the medical/patient interaction in general, in this case, in our view, inequality can be transformed into attitudes of violence, whose occurrence is related to the conjugation of women as well as patients, canceling them as subjects of rights, particularly sexual and reproductive rights. We understand a locus of power exercise instituted through a dominant ideology with norms that determine social roles for men and women based on sexual difference.[16] With the doctor in his relationship of care, with insertion of obstetric interventions, nullifying the right of choice of women, such as the autonomy of obstetric nursing, when the hegemonic power is established as the standard in the medical figure in obstetrics.

It is considered, from the testimonies, that "failures" occurred in the contracting of obstetrical nurses, in the form of implantation, since changing a care model is not a simple process because it requires several types of interventions regarding the structure of unity, of professionals, of collaboration as a team, of training in face of practices used, and mainly as institutional policy, however, the change must happen vertically, that is, it can not be simply imposed by a government strategy. Thus, there are still many conflicts to be overcome between models of care and care, and also in the division of occupied spaces between doctors and obstetrician nurses not consistent with the Program of Humanization at Delivery and Birth, together with the guidelines of the Network strategy Stork.

It is considered that the change becomes possible, since it is a political and institutional project, and the participants of the study exemplify in their testimonies that many hospitals have managed to overcome the obstacles and have managed to implant the humanized model, with the collaborative perspective between the doctors and nurses In this way, political will and efficient management are needed, and the Stork Network can not be seen as a government strategy that imposes changes, but rather as a strategy for actions that go beyond the financial transfer, but rather for the quality of the assistance.

This strategy causes managers, health professionals and the population in general to understand and discuss their issues at the time of their implementation, to be clarified in a practical and clear way, doubts and uncertainties, because only then can the transformation of the care model to the childbirth and birth practiced in the country, which does not place the pregnant woman as the protagonist of the process.[17] Thus, as occurred in places such as in the municipality of Rio de Janeiro, in the maternity Leila Diniz, the maternity Mariska Ribeiro; and in particular the Sofia Feldman maternity hospital in Belo Horizonte, where they modified a hegemonic model, with the insertion of a humanized model to guarantee a collaborative service for the quality of care backed by international recommendations for a healthy delivery.

CONCLUSIONS

The Stork Network appears in the maternal health scenario as an important universal health policy strategy, aiming at the implementation of a new model of attention to childbirth and birth, with the guarantee of access, better reception and resolution, to reduce the high rates of mortality and cesarean sections, so that it can implement a more welcoming and humanized model.

The study showed the process of implantation of obstetrical nurses, in agreement with the recommendations of the Stork Network, recommended by the Ministry of Health. The process happened with a great difficulty of the obstetric nursing performance, in which it was creating obstacles, mainly in the legitimacy in the attention to the childbirth and birth, with care only in the care and classification of risk, due to a great conflict coming from the medical team, by their insertion process. However, its implementation was followed by the main objective of changing the model of women's health care, from technocratic to humanized attention.

Thus, it shows the need to extend care based on the humanization of care, breaking the paradigms of health, in relation to the biomedical model, medicalized, and providing alternatives for a more welcoming and humanized care, through a shared care with nurses and doctor for quality care.

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