

PERFORMANCE OF OBSTETRIC NURSES IN PLANNED HOME BIRTH

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ABSTRACT

Objective: To understand the perception of obstetric nurses about their performance in planned home birth. **Methods:** This is an exploratory study with a qualitative approach. For data collection, semistructured interviews were conducted between June and August 2015 with seven obstetric nurses that were performing this type of care in Curitiba, State of Paraná, Brazil. The data were analyzed according to thematic groups, as proposed by Bardin, from which two categories emerged: obstetric nurses facing themselves; and obstetric nurses facing puerperal women. **Results:** It was observed that the work of nurses in homecare became a satisfactory and rewarding field of work, since it allowed greater autonomy. However, this function can also trigger difficulties, insecurity, and conflict of interpersonal relationships. **Final considerations:** The work of obstetric nurses in homecare was satisfactory and rewarding, and promoted autonomy. However, it caused difficulties, insecurities, and interprofessional conflicts. They believed that homecare included values that went beyond scientific and technological aspects, using a holistic look at that moment.

Keywords: Natural childbirth. Humanized birth. Home birth. Obstetric nursing.

INTRODUCTION

Currently, Brazilian obstetrics is in a scenario of discussion about the predominance of the technocratic model, due to excessive interventions and medicalization, which are some of the variables responsible for the difficulty in reducing maternal and neonatal mortality rates. However, Brazilian public policies focused on maternal health have been instruments for strengthening the process of changing the childbirth care mode⁽¹⁾.

One of the public strategies that encourage the change in obstetrical practices is the “Rede Cegonha” program, created by the Ministry of Health in 2011. This program seeks to ensure women's autonomy at childbirth, improving access to prenatal care, promoting safe and humanized births, and combating maternal and child mortality. At the same time, it encourages specialized training of nurses in obstetrics, as well as their direct insertion in childbirth care⁽²⁾.

In Brazil, care for vaginal dystocia-free birth can legally be provided by obstetricians, as well

as by nurses in cases of emergencies, obstetric nurses and traditional midwives registered in Brazil until 1959. The normalization and the responsibility of nurses in cases of emergencies or obstetric nurses are reaffirmed by the Resolution of the Federal Nursing Council, No. 516 of 2016, regarding the activities of nursing care provided to pregnant women, puerperal women, and those who have recently given birth, as well as follow-up of the evolution and childbirth, and performance of dystocia-free birth⁽³⁾.

Obstetric nurses can contribute substantially to the implementation of the new model of obstetric and neonatal care based on: care humanization; good practices according to scientific evidence; and the leading role of women during the childbirth process⁽⁴⁾.

Currently, the resolution abovementioned regulates the performance and responsibility of nurses, obstetric nurses, and midwives regarding care provided to pregnant women, puerperal women, women who have recently given birth, and newborns in obstetric services, natural

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childbirth centers, and other places that provide childbirth care⁽³⁾.

Regarding the place of childbirth, the specific guidelines for encouraging best practices in natural childbirth care, published by the National Commission for the Incorporation of Technologies into the Unified Health System (CONITEC), indicated that there were no significant differences related to maternal and neonatal mortality in the births that took place at the homes, when compared to hospital births⁽⁵⁾.

The National Guidelines for Natural Childbirth Care of the Ministry of Health, published in 2017, regarding planned home birth (PHB), states that *"in view of the Brazilian context, home birth is not available in the health system, so it is not possible to recommend it. However, the planning of home birth should not be discouraged"*^(6:17).

The homes are presented as a birth possibility for women who have good health conditions and do not have any factor that might generate the need for hospital support. The most similar environment to the former are natural childbirth centers, which may be intra-hospital or peri-hospital, and where obstetric care is provided by obstetric nurses or midwives⁽¹⁾.

In addition to the desire to reduce unnecessary interventions, the choice of home birth entails the desire to ensure the free movement and presence of the companions, the environment, and the embracement by the family, respecting their own beliefs and cultures⁽⁷⁾. Thus, in the light of the foregoing, the following research question emerged: What is the perception of obstetric nurses working in planned home births about their performance?

Given that nurses working in PHB are scarce in Brazil, the search in the literature indicated that the topic has still been little investigated in the country. This fact supports the conduction of the present study. This way, the goal was to understand the perception of obstetric nurses that provided care in PHB about their performances.

METHOD

This is an exploratory study with a qualitative approach. It was conducted with seven obstetric nurses working in PHB in the city of Curitiba, State of Paraná, Brazil. The sample was obtained

using the snowball method, i.e., the first interviewees indicated others, and so on, giving continuity to the study.⁽⁸⁾ The first interviewee was chosen for having affinity with one of the researchers. Finally, the sample was composed of seven obstetric nurses, corresponding to the total number of professionals who performed this type of care in the city.

The interviews were scheduled and performed at a place, date, and time suggested by the participants of the study. Data collection took place between June and August 2015. The interviews were recorded, thus ensuring participants' freedom to express themselves and the possibility of establishing a bond with the researcher. Subsequently, the interviews were transcribed.

As a form of data collection, semistructured interviews were carried out with the following initial question: What is it like to be a nurse who works in planned home birth?

As a method of data analysis, we used thematic-type content analysis, composed of four stages: organization of the analysis; coding; categorization; and inference⁽⁹⁾. The organization of the analysis consisted of pre-analysis. It was the organizational phase, which aimed to make operational and systematize the initial ideas, so that a precise scheme could be conducted in the development of successive operations, in an analysis plan⁽⁹⁾. In the present study, the whole of the interviews were transcribed. This procedure resulted in a 24-page document, which was read over and over again to allow researchers to become familiar with the reports. Subsequently, in the coding stage, a representation of the extracted content was performed by means of clippings, aggregation, and enumeration of the raw data from the text.⁽⁹⁾ In this sense, we determined the context units that were relevant for achieving the goal of the present study. These units were marked with different colors and received identification, resulting in seven topics. For the counting rule, they were organized according to the frequency of occurrence.

For the categorization stage, i.e., classification of constitutive elements of a set by differentiation and, then, regrouping these elements according to characteristics in common⁽⁹⁾, the topics were grouped by affinity,

forming two categories, namely: obstetric nurses facing themselves; and obstetric nurses facing the puerperal women and their families at home. Inference⁽⁹⁾ was performed through the discussion of the data from scientific articles and books related to the topic.

The participants of the study signed an informed consent form, in which the objectives of the research were explicit, as well as the assurance of participants' anonymity. The study began to be conducted after approval obtained from the Research Ethics Committee on Research with Humans of Positivo University, under certificate CAAE: 44101515.9.0000.0093, on 30th April 2015 (Opinion No. 1.046.525).

RESULTS

With respect to the seven participants of the study, six were female and one male. The mean age among them was 35 years, the minimum age being 26 years and the maximum 52 years. All of them were postgraduates in obstetric nursing, ranging from 11 months to 28 years, and the time spent working in PHB ranged from six months to six years.

Obstetric nurses facing themselves

This category emerged from the affinity of five topics, namely: autonomy and professional responsibility; professional satisfaction; insecurity; conflict of healthcare model; and practices of beliefs, cultures, and knowledge.

The interviewees reported that the practice of obstetric nurses who worked in PHB provided professional autonomy, which was full of responsibility, as reported by five of the seven obstetric nurses interviewed:

All autonomous work requires a challenge and greater discipline, and they bring many challenges. We get out of that professional prescriptive stance that we have, many of the things that we perform we do not learn in books, we learn from women and we suggest to others. (E2)

I see that home birth is a great environment for nurses' autonomy, but from the moment you have autonomy you have to take responsibility, people have to be very aware as well. (E6)

People also do not understand that when you have

an autonomous birth, you are a hundred percent responsible for that. Different from the hospital, if something happens, there is the institution that is there in front of us like a wall. And when you're working in home birth, it's you and you, there's nobody else. So, insofar as you have autonomy, you have independence and you have great responsibility. (E7)

As they performed their work in a more autonomous and responsible manner, they were able to adopt and develop the care model they believed in. In this way, professional satisfaction emerged as a consequence, as evidenced in six interviews:

We see childbirth as a portal, a spiritual, physical, and emotional transformation; we look at it in a holistic way. [...] It is challenging, because you are dealing with life and death, we have a life and to think about death, we deny it, and childbirth means life and death at the same moment. (E2)

You leave with joy, with satisfaction, with fullness; it is very gratifying indeed. I graduated 14 years ago. I haven't felt this satisfaction and this pride of being a nurse for 13 years (moved). (E3)

And for me, the professional with the staff is an emotion, it's wonderful, it's personal growth for me, because I see the transformation of these women, especially women, it's a transformation of the soul. (E6)

However, autonomy implies greater responsibility of performance when facing these women, the babies, and the whole families, and it might cause insecurity at certain moments. This characteristic was reported by three of the obstetric nurses:

Fear, insecurity and anxiety do not match a childbirth environment. In our experience, this fact has shown that it is more disruptive to the women and the whole process, and sometimes it gets in the way of the professionals if people are not there trusting that it is possible, that women can give birth, that women can have their babies in whatever position they want, with whom they want. (E3)

We always say that we will not be the first and will not be the last to have to deal with placental retention, postpartum hemorrhage, even a dead baby, that we have to be prepared for everything, the risk exists, but no one wants to get into statistics. It is that feeling of living dangerously, you know, because it is a life there, there are two

lives and life walks on the side of death. Do you understand? So, if anything happens, everything is broken, because when everything goes right, cute, well, you are the heroine, you assisted the childbirth, congratulations; and when things don't go right? Then you're the worst person in the world. (E4)

The choice of PHB by these professionals was mainly based on the autonomy of action in the face of the conflict with the model used in the hospital environment, as evidenced in one interview:

I'm in the hospital, I always worked in the maternity ward too; we are faced with some situations which are not what we believe in. (E5)

However, assisting PHB is a way of putting into practice and sharing beliefs and cultures, as well as a moment of personal transformation and growth. This topic was found in three interviews:

They are very strong things that change the whole course of life, so we have a lot of faith, seeing our beliefs whenever we go to work with childbirth, we always try to focus, we try to take our faith and our protectors with us, we are never alone, but this occurs within our beliefs, every professional has a view about it. (E2)

I also work with aspects of traditional culture, so I work as a traditional midwife. I even bring many techniques and many habits of traditional midwives from Brazil and Mexico, I use them a lot, so there are several non-pharmacological procedures that we can perform, lighter technologies to cope with it, a removal let's say. (E6)

Assisting home birth is not just something I like to do for other people; I like to do it for myself. Because every time I assist childbirths, I get myself better and better. (E7)

Obstetrician nurses facing puerperal women and their families at home

This category was built from the grouping of two topics, namely: humanization based on evidence; and bond. The professional practice of obstetric nurses, especially those who work in home birth, understands women as the protagonists of their childbirth, providing elements that enable their empowerment,

coupled with humanized evidence-based care. This topic was evidenced in six interviews:

We try not to disrupt, the arrival of the professional can also generate tension, regulating the time for women to give birth, a responsibility that does not exist. We try to handle it more quietly. Some women need more of our presence and it is our responsibility to guide these women to use non-pharmacological methods for the relief of pain, conversation, massage, breathing techniques, the use of different positions searching for better comfort. Because home birth includes this issues of respect, possibility. (E1)

As we are inside the house, we are being invited to that, so we always have to respect it, gratitude and care, it is a moment of great intimacy, that we have to respect, to be in tune with the group, be in tune with the women, be sensitive, but never failing to realize that our main responsibility there is technical. (E2)

Working in home birth is doing so from a perspective of nature; it is based on a triad: (1) the autonomy of these women; (2) scientific evidence; and (3) the physiology of childbirth. It is this tripod that needs to be in balance. When you think about the autonomy of these women, you have to think about their perspectives as well, emotional, cognitive, so you have to think about these women in a general manner, life history, sensations, emotions, feelings, beliefs, values. Because I can only improve others if I improve myself. It is the way to improve the world. In the care provided for home birth, you have to necessarily work with another paradigm, the paradigm that the other is capable. (E7)

Given the possibility of home birth, obstetric nurses understand that, to provide care, it is necessary to establish a bond with the family, as evidenced by five interviewees:

We are invited to join this family, so we have to understand a little how that logic, that system, and the culture of each couple works. The birth plan is not a specific role, but ends up being built together with the couple. We end up understanding some things that the couple may or may not want. (E1)

We talk a lot, not only about what she's feeling, it's about the family, about the mother, about the father, about the little child, about the husband, it's like a more general consultation, so I stay more than two hours in the woman's house every time I go to talk. (E4)

DISCUSSION

Obstetric nurses facing themselves

Direct care for childbirth performed by obstetric nurses is supported by the Resolution No. 516/2016 of the Federal Nursing Council (COFEN). When the occurrence of dystocia is detected, all the necessary measures should be taken until the arrival of the medical team, through interventions that ensure the safety of the binomial mother-child according to the nurses' technical-scientific training—and follow-up of the family under their care, from hospitalization to discharge.

The legislation is part of the elements that support and protect obstetric nurses, providing autonomy and, therefore, greater professional satisfaction. In this way, satisfaction is directly related to the work environment, the established bonds between patients and family members, social diversity, technical-scientific knowledge relating to professional practice, the autonomy and safety of the professionals, and follow-up of the patients' progress related to the care provided⁽¹⁰⁾.

The professional recognition gained due to effective performance makes the workers feel protagonists in their work process, which favors autonomy and commitment. When the workers perceive the positive outcomes resulting from their effort, there is job satisfaction and development of higher-quality care⁽¹¹⁾.

At the same time that the professionals acquire autonomy and feel satisfied, a sense of insecurity may also emerge. When assisting puerperal women, obstetric nurses should be aware of possible complications that can occur. However, in order to work safely and minimize risks, by means of early identification of emergencies and acting efficiently, a high level of technical and scientific knowledge is essential.

In professional practice, there are disagreements in the perception of nurses and doctors regarding care provided to puerperal women, thus making the relationship between the multiprofessional team deficient. It is necessary that professionals develop effective and interdisciplinary actions, combining aspects

of physical, social, spiritual, psychological, and biological care provided to women⁽¹²⁾.

Conflicts between physicians and nurses can generate ethical problems, affecting the relationships within the multidisciplinary team, and interfering in the quality of patient care. According to the literature, problems in interpersonal relationships are the predominant stress factors among professionals⁽¹³⁾.

The conflicts originate from the dispute of command and governance, in the conquest of autonomy. Frequently, they emerge in the face of divergence of behaviors, mainly in the assistance based on different models of childbirth care. In this sense, the culture of humanization and respect in childbirth are the counterpoint of the technological and interventionist practice.

Obstetrician nurses facing puerperal women and their families at home

About 140 million women without risk factors give birth worldwide every year. However, there has been a substantial increase in the last two decades in the number of interventions during childbirth in order to initiate, accelerate, finish, and regulate or monitor the physiological birth process. This increased medicalization of birth processes tends to impair the women's own ability to give birth, and may adversely affect the experience of the parturition process. The latest guidelines for childbirth care of the World Health Organization (WHO) are based on the premise that most women desire labor and physiological childbirth in order to achieve personal fulfillment and involvement in decision-making, even when clinical interventions are necessary or desired⁽¹⁴⁾.

It is worth highlighting nursing, because it meets the needs of women including physical, social, spiritual, psychological, and biological aspects, thus establishing humanized care. Care based on good practices ensures that the moment of birth is experienced in a unique, positive, and enriching way. Listening, embracing, guiding, and creating bonds are essential elements in the provision of care. As well as ensuring privacy, autonomy and respect are indispensable in the care provided to puerperal women⁽¹²⁾.

The promotion of puerperal women's autonomy means providing information to these women. It also means providing freedom for their choices, including involvement in care decisions. Thus, women's sexual and reproductive rights are respected and, as a consequence, nurses develop a less interventionist obstetric practice⁽¹⁵⁾.

The bond established between puerperal women, professionals, and families is extremely important, given that women may feel fragile or insecure while given birth. Thus, the trust that the professionals promote in these women makes them trust in themselves, thus promoting a therapeutic relationship and making the moment of childbirth an experience of life, pleasure, and love⁽¹⁶⁾.

The environment where the childbirth takes place may interfere with the outcomes of its evolution. At home, puerperal women are safe; they can be accompanied by individuals that love them, which makes them feel free to express their feelings and accomplish their wishes. On the other hand, the institutionalization of childbirth and interventionist practices exert an influence, causing loss of puerperal women's autonomy and increasing the medicalization and interventional hospital practice^(17,18).

Hospital units do not always ensure quality care, given that the overcrowding of the service and the observation rooms that become hospitalization areas do not favor humanized care. In addition, in most cases, professionals do not have adequate working conditions to provide women with comprehensive care, which may expose them to risks that could be avoided⁽¹⁹⁾. A study carried out in two maternity hospitals in Maringa, State of Paraná, Brazil, with 358 puerperal women, showed that 332 had undergone some intervention, predominantly the primiparous women and with vaginal delivery. After the cesarean section (57%), labor induction (42.2%) and episiotomy (37.7%) were the most performed procedures, which were the most observed factors in those women.

According to scientific evidence, the systematic review indicated that women required fewer interventions and felt more satisfied in the process of childbirth assisted by obstetric nurses or midwives⁽²¹⁾. This way, the last guideline for

care provided for vaginal childbirth of the WHO takes into consideration that childbirth is a physiological process that can be performed without complications for most women and infants. At the same time, it recognizes the positive experience of the childbirth process as the experience that meets or exceeds personal and sociocultural beliefs and expectations, including giving birth to a healthy baby in a clinically and psychologically safe environment, with continuing practical and emotional support from a birth partner and a technically competent clinical staff⁽¹⁴⁾. Thus, the safe home becomes a adequate place for the childbirth process.

PHB is associated with significantly lower numbers of interventions, greater maternal satisfaction, and increased cost-benefit ratio in comparison to childbirth taking place in a hospital obstetric center^(12,22). It may be followed-up by obstetric nurses, through a routine of encounters that occur prior to childbirth, with quality prenatal care and the request of laboratory tests necessary for a clinical evaluation. If any risk for the mother and/or the baby is detected, the referral to the closest hospital is performed at any childbirth stage⁽²³⁾.

Individuals who choose home birth seek for skilled and qualified professionals for this type of care, not to rescue the past, but to revitalize birth as something intimate and familiar. For these couples, the home is the safest and most suitable place for childbirth. The main reason for this choice of couples is the appreciation for the simplicity of a natural childbirth⁽²⁴⁾. They want a warm birth, surrounded by professionals who stimulate good practices and respect, and discuss behaviors with the women, making them active beings endowed with autonomy⁽²⁵⁾.

However, in the midst of the Brazilian reality, some medical associations have taken the stance of not supporting physicians who assist home birth. Thus, obstetric nurses have formed care groups throughout the country, so that the wishes and expectations of pregnant women and puerperal women provided that the clinical situations are favorable—are met and the experience of the childbirth process is positive, as advocated by the WHO.

FINAL CONSIDERATIONS

The assessment of the perceptions of obstetric nurses who performed PHB made it possible to understand that the work of health professionals' at the patients' homes becomes satisfactory and rewarding, because this modality provides greater autonomy. However, it entails difficulties, insecurities, and interprofessional conflicts.

Obstetric nurses working in PHB believe that this care model encompasses values that go beyond scientific and technological aspects, using a holistic look at that moment.

In Brazil, there has been an increase in this childbirth method, which has historically been used in other countries. However, there are still legal and moral issues that become obstacles for greater expansion and diffusion in society. Studies on this model are still scarce; therefore, it is suggested that studies of this nature should be conducted and published in order to encourage PHB, making it a scientifically strong practice in the country, promoting and implementing it through public health policies.

ATUAÇÃO DO ENFERMEIRO OBSTETRA NO PARTO DOMICILIAR PLANEJADO

RESUMO

Objetivo: Compreender a percepção que o enfermeiro obstetra que atende ao parto domiciliar planejado tem de sua atuação. **Métodos:** Trata-se de um estudo exploratório de abordagem qualitativa. Como técnica de coleta de dados, foram utilizadas entrevistas semiestruturadas, realizadas no período de junho a agosto de 2015, com sete enfermeiros obstetras que realizavam este tipo de parto em Curitiba, Estado do Paraná. Os dados foram analisados segundo grupos temáticos, proposta por Bardin, dos quais emergiram duas categorias: o enfermeiro obstetra diante de si; e o enfermeiro obstetra diante da mulher. **Resultados:** Identificou-se que a atuação do enfermeiro em domicílio torna-se um campo de trabalho satisfatório e gratificante, pois lhe possibilita maior autonomia. Entretanto, esta função também pode desencadear dificuldades, insegurança e conflito de relações interpessoais. **Considerações finais:** A atuação do enfermeiro obstetra no domicílio constitui um trabalho satisfatório, gratificante e que proporciona autonomia. Entretanto, traz dificuldades, inseguranças e conflitos interprofissionais. Acreditam que a assistência domiciliar abrange valores que vão além dos aspectos científicos e tecnológicos, utilizando-se de um olhar holístico sobre esse momento.

Palavras-chave: Parto normal. Parto humanizado. Parto domiciliar. Enfermagem obstétrica.

ACTUACIÓN DEL ENFERMERO OBSTETRA EN EL PARTO EN CASA PLANEADO

RESUMEN

Objetivo: comprender la percepción que el enfermero obstetra que atiende al parto en casa planeado tiene de su actuación. **Métodos:** se trata de un estudio exploratorio de abordaje cualitativo. Como técnica de recolección de datos fue utilizada entrevista semiestructurada, realizada, en el período de junio a agosto de 2015, con siete enfermeros obstetras que realizan este tipo de parto en Curitiba, Paraná-Brasil. Los datos fueron analizados según grupos temáticos, propuestos por Bardin, de los cuales surgieron dos categorías: El enfermero obstetra ante sí; y el enfermero obstetra ante la mujer. **Resultados:** se identificó que la actuación del enfermero en casa se vuelve un campo de trabajo satisfactorio y gratificante, pues le posibilita mayor autonomía. Sin embargo, esta función también puede desencadenar dificultades, inseguridad y conflicto de relaciones interpersonales. **Consideraciones finales:** la actuación del enfermero obstetra en el domicilio constituye un trabajo satisfactorio, gratificante y que proporciona autonomía. Pero, trae dificultades, inseguridades y conflictos interprofesionales. Crean que la atención en casa abarca valores que van más allá de los aspectos científicos y tecnológicos, utilizándose de una perspectiva holística sobre este momento.

Palabras clave: Cáncer. Cuidados Paliativos. Cuidadores Familiares. Enfermería.

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