

# Challenges of midwives in labor and birth care: a descriptive and exploratory study

## Desafios de enfermeiras obstétricas na assistência ao parto e nascimento: estudo descritivo e exploratório

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### ABSTRACT

**Objective:** to identify and analyze the challenges faced by obstetric nurses regarding their insertion in labor and birth care. **Method:** descriptive exploratory study, with a qualitative approach, involving three focus groups with 16 nurse midwives from an improvement training, held between August and November 2019. The statements were recorded and submitted to a content analysis in the thematic modality. **Results:** the main activities that stood out as challenges faced by obstetric nurses were the work demand, the overload of bureaucratic activities, conflicts with the health team in shared care, the process of limited autonomy of the obstetric nurse, and the intense need to validate one's own technical competence before the health team. **Conclusion:** expanding work processes and shared health management in an interprofessional team, in line with scientific evidence, favors the improvement of knowledge and collective dialogue.

**Descriptors:** Obstetric Nursing; Maternal-Child Health Services; Professional Training.

### RESUMO

**Objetivo:** identificar e analisar os desafios apresentados por enfermeiras obstétricas, quanto à inserção na assistência ao parto e nascimento. **Método:** estudo descritivo, exploratório, abordagem qualitativa, com realização de três grupos focais com 16 enfermeiras obstétricas do curso de aprimoramento, entre agosto e novembro de 2019. Os depoimentos foram gravados e submetidos à análise de conteúdo na modalidade temática. **Resultados:** destacaram-se como desafios das enfermeiras obstétricas a demanda de trabalho e a sobrecarga com atividades burocráticas; os conflitos com a equipe de saúde na assistência compartilhada; o processo de autonomia limitada da enfermeira obstétrica; e a intensa necessidade de validar a própria competência técnica diante da equipe de saúde. **Conclusão:** ampliar os processos de trabalho e a gestão em saúde compartilhada em equipe interprofissional, alinhados às evidências científicas, favorece o aprimoramento de saberes e o diálogo coletivo.

**Descritores:** Enfermagem Obstétrica; Serviços de Saúde Materno-Infantil; Capacitação Profissional.

### INTRODUCTION

The Brazilian obstetric scenario, throughout its history, has been subjected to high rates of maternal and neonatal morbidity and mortality. Among the indicators of the above problems are the high number of cesarean sections, disrespect for female autonomy, and women's sexual, reproductive and human rights, culminating in a medical-hegemonic, hospital-centric, and routinely interventionist care process<sup>(1)</sup>.

Since this is not an exclusive problem in Brazil, official international and national health agencies have joined forces to align qualified and safe practices with the needs and rights of women, their babies, and their families. Thus, the aim is to encourage the strengthening of a humanized care model based on updated scientific evidence, prioritizing labor and birth care as a physiological event that, as such, requires more care than control<sup>(1-4)</sup>.

In Brazil, the Ministry of Health (MS in Portuguese), through the National Humanization Policy (PNH in Portuguese), addresses practices with humanization

difficulties as precarious forms of organization in work<sup>(4)</sup>. The humanization agenda is expanded to new training offers, highlighting the relationship between humanization and health training<sup>(5)</sup>.

In this context, it becomes relevant to consider training as a technical and political strategy, in which training, care, and management processes constitute an inseparable triad in the production of work. Training as a collective intervention strategy presupposes engagement and stimulation of co-learning between actors, promoting dialogues and reflections capable of provoking changes in managing and assisting patients<sup>(3,6)</sup>.

Given the intrinsic presence of training in professional practice and the potential to strain work processes, the importance of teaching hospitals and models for future professionals becomes evident. These institutions emerge as powerful transformation initiatives, reverberating the actions instituted and presenting great relevance in the paradigmatic change of the obstetric care model<sup>(9)</sup>.

In this scenario, the Improvement Training for Obstetric Nurses (CAEO in Portuguese), focusing on the parturition and birth component, has been operational since 2017 in the national territory, aiming to reorient the obstetric field based on the Improvement and Innovation Project in Obstetrics and Neonatology Care and Teaching (APICEON in Portuguese)<sup>(3,7)</sup>.

This project, funded by the MS and partially implemented by the *Universidade Federal Fluminense* (UFF), has been carried out with a focus on care, management, and training processes related to labor and childbirth<sup>(8)</sup>, through a model based on scientific evidence, humanization, safety and guarantee of rights<sup>(1-8)</sup>.

In this way, the methodological component of the CAEO/MS/UFF proposal has made it possible to improve the professional practice of obstetric nurses contributing to the collective formation of the work process, including different subjects: leading professionals, management members, and university professors/students. These everyday relationships in obstetric care services support changes in shared care management<sup>(6,8-9)</sup>.

Critical-reflective-dialogued exchanges between health professionals and teachers bring together the forms of collective knowledge for care and facilitate the training of the workforce in obstetric care, enabling reflections on their own doing and changes in the conception of work. The CAEO uses a dialogic approach developed by Paulo Freire as a proposal for collaboration and trans-

formation of the collective reality of the work of obstetric nurses<sup>(10)</sup>.

In this context, obstetric nursing must be articulated with the support of the management of the obstetric service and education, supporting and strengthening obstetric nurses' roles in the field of labor and birth, increasing their autonomy in the services, and reinforcing the process of co-participation in the collective organization of work. This care/management/training process occurs by stimulating conversations between the Public Health and Educational Policies, especially between the National Humanization Policy and the Permanent Education Policy in Health<sup>(11)</sup>, providing a basis for the collective transformation of obstetric nurses' reality.

Thus, the study presented the following research question: What are the challenges faced by obstetric nurses from an improvement training concerning their insertion and performance in the labor and birth setting?

Thus, the objective was to identify and analyze the challenges faced by obstetric nurses regarding their insertion in labor and birth care.

## METHOD

This is a descriptive exploratory research with a qualitative approach guided by the Consolidated Criteria for Reporting Qualitative Studies, having obstetric nurses trainees of the Improvement Training for Obstetric Nurses as participants, a program funded by the Brazilian Ministry of Health and partially carried out by the Aurora de Afonso Costa Nursing School at UFF.

The scenario comprises the CAEO/MS/UFF. The Brazilian Ministry of Health financed this training, and a cooperation agreement was signed between this Ministry and the UFF through the EEAAC and the technical area of Women's Health of the Ministry of Health.

The training is characterized by the immersion of eight obstetric nurses per class, for 15 days, in the State of Rio de Janeiro, Brazil, where they perform 96 hours of technical improvement in service in two maternity hospitals in the cities of Niterói and Rio de Janeiro, and 36 hours of dialogue workshops held at UFF, with the steering group and expert guests, totaling 132 hours.

At the end of this period, an evaluation workshop is held, in which the CAEO team members and the leading group participate, using dialogue as a form of exchange to welcome perceptions, strengths, weaknesses, and challenges. The intention is to approach collectively the return to

the unit of origin of the obstetric nurses being trained, with numerous ideas and tools, inserting them into a dynamic institutional context.

Sixteen nurse midwives from CAEO classes I and II participated in the study. Participants considered eligible for the study had to meet the following criteria: 1) midwives trained at the CAEO/MS/UFF; 2) acting in educational institutions interested in changing the care model; 3) insertion of nurse midwives in labor and birth care at the national level; and 4) registration as a specialist in the Regional Council of Nursing. As for the exclusion criterion, the study was restricted to those who completed the improvement training. The sample was delimited by convenience, in which the participants were approached in person by the main researcher, who invited them to participate in the research. None of the trainees approached refused to participate in the study. The investigation was based on the use of a focus group for data production, carried out between August and November 2019. The students were divided into two groups, and three meetings were held in a classroom at UFF, lasting approximately 150 minutes. The group had the participation of a moderator (main researcher), an observer researcher (in charge of making the recordings), and eight participants from each group.

In the first focal meeting, the trainees were invited to talk and expose their personal understanding of the perspectives regarding the insertion in labor and birth care in the unit where they worked. Then the researcher led the group into the debate. In the second focal meeting, a critical-reflexive analysis was carried out based on collective discussions. In the third focal meeting, the educational intervention was evaluated based on the perception of the challenges for the insertion of the trainee obstetric nurses in their respective health units. In each meeting, the observer recorded the participants' speeches using a digital audio capture device. The recordings were authorized by the participants and fully transcribed.

A content analysis in the thematic modality<sup>(11)</sup> was used for the analysis of the data, to discover the cores of meaning, whose established phases were: 1) pre-analysis of the testimonies; 2) exploration of the material and treatment of the results; and 3) inference and interpretation. Simple computer resources (colorimetry in Microsoft Word®) were adopted for the material's organization and coding, making it possible to choose the Registration Units (RU).

The study was approved on July 3, 2019, by the Research Ethics Committee of Hospital Universitário Antônio Pedro at UFF, according to opinion no. 3,434,805/2019 and CAAE no. 12127619.8.0000.5243, as provided in the Resolution of the National Health Council No. 466/2012. After presenting the research scope to the participants, they were invited to participate in the study. The deponents were identified by the letter (T) of Trainee, followed by a numerical number corresponding to the sequence in which the interviews were carried out (T1, T2, T3, ..., T16) to ensure confidentiality, anonymity, and reliability. In addition, voluntary participation was guaranteed, and all participants signed the Informed Consent Term.

## RESULTS

As for the profile characterization, the participants were mostly women (15, 94%), married (7, 44%), brown (8, 50%), and white (7, 44%), aged between 32 and 47 years, resulting in an average of 36 years of age. Regarding training, specialization was predominant (14, 87%), with an expressive average remuneration between five and ten minimum wages (8, 50%) and three to four minimum wages (7, 44%). Geographically, they are equally distributed, with two trainees from each Brazilian region, covering 11 health units in nine Brazilian states and the Federal District.

Based on the methodological path presented, the following RUs were listed: excess service; work demand; professional sizing; activity overload; staff reduction; professional autonomy; insertion in women's care; institutional recognition; professional recognition; competence; quality process; and shared care.

These RUs, in turn, supported the construction of the following thematic unit, namely: Challenges for the insertion of obstetric nurses in the institutional routine of the trainees, which supported the construction of the following category: 1) Challenges in the performance of the trainees: issues of work overload, limitation of the professional autonomy, judgment of obstetric behaviors, and insertion of good practices in daily life. Challenges in the performance of the trainees: issues of work overload, limitation of the professional autonomy, judgment of obstetric behaviors, and insertion of good practices in daily life. The improvements made by the CAEO/MS/UFF, from the dialogues in the focus group, pointed out that the obstetric nurses had an excessive

demand for bureaucratic activities, contributing to the overload of institutional actions. In addition, the need for adequate dimensioning for obstetric nursing professionals was observed in the reports, making it possible to provide quality care in the field of labor and birth, inherent to the improvement process experienced.

*I don't think we (the obstetric nurses) work as midwives. We end up doing other things (bureaucratic work), and we can't handle the service. (T1)*

*I work as a midwife when possible because we have a whole series of bureaucracy to solve on duty. (T6)*

*Our work today is very bureaucratic. We are able to be present in the assistance only if we step away from the bureaucracy of supervision; it is a lot for us to do [...] It turns out that the woman is not benefited because we have to deal with the bureaucracy, the paperwork. I can't spend my shift missing anything. (T12)*

There are numerous conflicts in the work performance in the context of labor and birth, both on the part of the medical team and the obstetrical nursing, especially in the work processes, in which there is a lack of alignment of the conduct of good practices for team care. In this sense, among the challenges pointed out in the speeches of the trainees, is the lack of knowledge of scientific evidence on the part of the teams and managers. According to them, the doctor is seen as the "holder of the know-how". Thus, there is a limitation to the performance of obstetric nurses due to the lack of implementation of shared care between teams or the management's lack of ordering collective sharing processes.

*The pediatrician arrived at the time the baby was being born and the room was in the dark. Then she turned on the light! [...] And I said: "Can you turn off the light please? When he finishes being born [...], then you light it up". The pediatrician went out, complaining. Then I went to explain why the penumbra was necessary. (T8)*

*When I'm going to do other things, the doctor comes and says: "no, she has to lie down!" Then they (nursing staff) say this when I*

*arrive [...] "She has to lie down because the doctor said so [...] as not to lose the IV access". And then she ends up staying like that! Of course, as much as we always talk, we know that the technicians will listen to the doctors. (T13)*

*Nurses and medical coordinators need to work together; they need to be open to listening, discussing, and using scientific evidence to expand safe care. Then, we will have a path of care together, one helping the other. (T16)*

There is a real need to expand the workforce of obstetric nurses in caring for women in the field of labor and birth and the care practices must be shared by teams working in maternity wards. When there is any intercurrent in the physiological process of childbirth, there is a need for shared work. In this way, the management of the service must be aligned with this movement of appreciation and autonomy of the health teams.

*If everything goes well (in childbirth care), great. If everything goes wrong, it's over, and this whole thing of nurses delivering babies is shut down. These expressions are common in everyday life. We have to work together as a cohesive team. The only winners are the woman and the baby. The manager, who is still learning to work with this perspective (shared work), must be present. (T2)*

*So, it's a kind of thin line. Everything is going well, but if there is a little problem, everything goes wrong, and it can't be like that, especially with us (obstetric nurses). That is why we need shared care, multidisciplinary team meetings, and a present manager. Then, collectively, we can move forward. (T8)*

Good practices in the field of labor and birth in the face of the autonomy of obstetric nurses constitute major challenges for the services. Based on scientific evidence, strengthening shared care expands qualified and safe care for women and their babies, ensuring the reduction of avoidable obstetric complications in the parturition and postpartum process.

*I think that our autonomy will be developed when we master the scientific evidence and collectively build conditions to discuss and share care with doctors and the entire team.*

*This improves the practice of collaborative care. We learn together. (T13)*

*The technical team needs to be involved in the process. Our initial focus is the technical team. They need to understand the reason for good practices. We do not make the patient bath just to relieve the pain a little bit. It's not just that! We (the technical team) have to understand why we do what we do [...] we think about care processes together. (T15)*

Given the above, there is a need for management to effectively promote the insertion of trained obstetric nurses in the context of women's care, favoring care based on technical-scientific knowledge and the collaborative interprofessional model to guarantee respectful, safe, and qualified care.

## DISCUSSION

The excess of bureaucracy in the hospital service constitutes an important impediment to the performance of the trainees in acting directly with women in the field of labor and birth. Thus, the participants pointed out, as challenges, the break with bureaucracy in obstetric care services. This bureaucracy contributes to a greater dissatisfaction, on the part of health professionals, in not providing care directed to women in the parturition process, as a reason for the specific training provided and an object of discussion during the CAEO/MS/UFF training.

The bureaucratic demands are extensive in the daily routine of nurses, with more time devoted to administrative actions, including the quantitative concern of service needs and institutional goals to be achieved, with little emphasis on quality of care. In this way, bureaucracy makes institutional rules and norms an imperative assignment in nursing activities<sup>(13)</sup>.

Given the above, in addition to the bureaucratization in the practice of nursing, the obstetric nurses also pointed out the work overload directly linked to their dissatisfaction in wanting to exercise direct care for women and their babies. Thus, dissatisfaction with work overload and precarious conditions often lead to exhaustion, impacting productivity, performance, health and well-being, life satisfaction, and user satisfaction, resulting in absenteeism, higher turnover, and damage to the organizational citizenship<sup>(14)</sup>.

Thus, adequate nursing dimensioning is necessary, following Resolution No. 543 of the Federal

Nursing Council (COFEN in Portuguese), of April 18, 2017, based on the nature of the health service, the nursing service, and the patient's status<sup>(15)</sup>. This dimensioning aims to ensure quality obstetric nursing care, promoting safety for women and their babies, based on the necessary dimensioning of professionals and institutional attributions. In addition to the quality of the obstetric care provided, the dimensioning favors the change of the obstetric model, allowing the insertion of the obstetric nurse in the direct care during labor and birth, promoting the performance in the collaborative molds and the centrality of the woman, and no longer the model centered on the figure of the doctor<sup>(16)</sup>.

Since the CAEO/MS/UFF takes place in the context of technical-scientific improvement of obstetric nurses in labor and birth care, these purposes must be aligned with those of the institution of origin, aiming to guarantee direct care to women from the perspective of autonomy of obstetric nursing professionals. Thus, as a strategy to promote qualified and safe care, it is necessary to guarantee the insertion of trainee obstetric nurses in healthcare, making cooperative and inclusive management necessary to guarantee Law nº 7,498, of June 25, 1986, which establishes the professional practice of nursing, legitimizing the role of the obstetric nurse in the assistance in labor and birth for women at usual risk. Along with interprofessional and shared care, these care models significantly contribute to changes in work processes, which are fundamental conditions for maintaining the quality of care and improving health indices<sup>(17)</sup>.

Thus, institutional alignment is necessary, so that nurse midwives can actively participate in the reconstruction of care for women and their babies. The objectives of the CAEO/MS/UFF, in line with the MS and WHO, go far beyond improving nurse midwives, encompassing the potential to exercise a caregiving space, promote changes in the interprofessional model, and continuous collaboration between relationships and obstetric care processes. Without this perspective of changes in the care process encompassing management and intervention, the implementation of current public health policies is not guaranteed<sup>(1-9,11,18)</sup>.

Thus, given the challenges related to bureaucracy, work overload, and the dimensioning of obstetric nurses, institutional management must modify processes and guarantee the prerogatives of nursing legislation, promoting an adequate

number of professionals to exercise direct care for women and their babies.

In the planning of obstetric care, the creation of the necessary conditions must be included so that both nurses and doctors have governance in the practice of care in the field of labor and birth. When there is support for shared care from the perspective of different forms of knowledge, this directly reflects on the humanization of care, the optimization of healthcare resources and costs, and the healthcare quality improvement considering the demands of service users<sup>(17)</sup>.

In this sense, the nurse-midwives trained at the CAEO/MS/UFF experienced a training anchored in the technical-scientific aspects of the performance of obstetric nursing, with the applicability of good practices of labor and birth based on scientific evidence, highlighting the physiology of parturition and the reduction of unnecessary interventions. These conditions guide public policies for obstetric care, corroborating the WHO's<sup>(1)</sup> and the MS<sup>'(18)</sup> recommendations for childbirth. In this way, the search for the applicability of the improved tools in the CAEO/MS/UFF stands out for the possibility of valuing obstetric nurses who, in this process, legitimize their performance in the professional nursing practice. Therefore, based on the management of health services, they need to guarantee professional performance in the field of labor and birth, advocating autonomy and safety in work processes<sup>(17)</sup>. These factors are guaranteed by Law No. 516, of June 24, 2016, of COFEN, which deals with the autonomy of obstetric nurses, when approaching their legal exercise and the support in the Laws and Resolutions that govern the performance in the field of care.

Despite the legal prerogatives, the nurse-midwives trained at the CAEO/MS/UFF recognized the existence of challenges in the exercise of their daily routines at health institutions. It is necessary to expand shared care in order to dialogue with the knowledge inherent to labor and birth, under the logic of understanding parturition as a physiological event with a focus on women, implementation of good practices based on scientific knowledge, reduction of unnecessary interventions, and exercise of interprofessional interactions to guarantee more qualified and safe care.

It is paramount that management is included in the discussion about the rupture of the care model, supporting obstetric nurses for the pro-

tagonism of their performance, and deconstructing the idea that parturition is exclusive to medical knowledge. Therefore, the professional development of improving nurse midwives implies changes in attitudes based on scientific knowledge, replacement of the care model, and establishment of care relationships with women and their babies<sup>(17)</sup>.

WHO and partners consider interprofessional collaboration in education and practice as an innovative strategy that plays an important role in reducing the global crisis in the health workforce, directly influencing the quality of care<sup>(7-8)</sup>. Thus, they bring the perspective of the practice of collaborative (shared) health care, which can occur when different areas of health provide services based on the integrality of health, involving women and families, professionals and communities for health care of the highest quality, at all levels of the service network.

In this way, the collaborative interprofessional practice is an essential element of the work of the health team, producing an effective, integral work process, facing the needs of the woman and the baby, contributing to the therapeutic success<sup>(19)</sup>, with the transformation of the ways of performance in care in the field of labor and birth, within the scope of the objectives of the CAEO/MS/UFF. Thus, the complexity of health needs and the organization of services point to a growing tendency to replace the isolated and independent work of professionals with teamwork based on interprofessional collaboration<sup>(19)</sup>.

The collaborative interprofessional model must be aligned with an innovative practice of obstetric care and the improvements of the CAEO/MS/UFF as the potential for the applicability of institutional changes, including the reorganization of work processes beyond the uniprofessional logic. For this, the management of the service must move important structures in favor of the work process and the quality of maternal and child care because, when there is dialogued engagement and co-responsibility of care, all these conditions favor effective and safe care.

Scientific evidence constitutes an important link between the autonomy of obstetric nurses and their professional practice, guaranteeing an assistance based on knowledge, respecting the physiology of parturition, and aiming at the quality and safety of labor and birth. Thus, science must be linked daily to the work of obstetric nurses, including those who are being trained at the CAEO/MS/UFF, being recognized as an

inducer of changes in work processes, as well as institutional routines and protocols, whose review must be permanently aligned with this process of recognition of scientific knowledge to increase the quality of care for women and their babies, an essential component of maternal and child care services<sup>(3,19)</sup>.

In this sense, there is a need for obstetric nurses, physicians, managers, users, and all health teams of institutions to take ownership of scientific evidence, so that they can master the applicability of collaborative care to women in the process of parturition, according to the national and international recommendations, and understand the real needs of women in the field of sexual and reproductive health.

Thus, the challenges faced by nurse midwives are posed, and the evidence shows the need for institutional support since their performance will contribute to more qualified and safe care, within the change of the logic of the parturition model<sup>(3)</sup>, in that the CAEO/MS/UFF enhances the collaborative interprofessional model for the work process, pointing to advances in the understanding that this model brings a perspective of reorganization of health services, in favor of dialogue and collaboration in the different ways of knowing and caring.

The limitation of the study is based on the impossibility of analyzing the care protocols of the institutions involved and the need for an insertion plan of the trainee nurse midwives in labor and birth care settings.

## CONCLUSION

Midwives trained at CAEO/MS/UFF participated in a training program focused on labor and birth, strengthening professional practice tools. After this immersion, when they return to the reality of their work in their respective institutions of origin, the nurse-midwives will be able to identify numerous challenges to exercising an independent practice in a dynamic institutional context. Thus, management support to reinforce the interprofessional team's collaborative work becomes essential for the insertion and effective

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performance of the obstetric nurse in the scope of labor and birth.

However, these professionals have faced several obstacles to implementing care in the parturition process, such as excessive bureaucratic attributions, work overload, and lack of adequate staffing, directly impacting the autonomous professional exercise of obstetric nurses. Another relevant issue is the constant need to mediate professional conflicts regarding the practices implemented in the daily care of obstetric nurses, constituting a major obstacle, especially concerning the need to guarantee care practices based on current scientific evidence, with a focus on women's rights.

In this context, the collaborative interprofessional model is inserted with the perspective of changing work processes to promote comprehensive care, providing clues to bring together the specific knowledge of each profession, characterizing the expansion of bonds of trust and co-responsibility, promoting safe and qualified care. Therefore, the collaborative model brings to light the hierarchical rupture of obstetric care, enhancing a scenario of relationships that respect the positions and autonomy of the respective professions, focusing on the well-being of women and their babies.

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## CONFLICT OF INTEREST

The authors have declared that there is no conflict of interest.

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