Cogitare Enfermagem

ORIGINAL ARTICLE

BIRTH AND CHILDBIRTH ON THE FRENCH-BRAZILIAN BORDER: NURSES' PERCEPTIONS

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ABSTRACT

Objective: to understand nurses' perceptions of childbirth and hospital birth assistance on the Franco-Brazilian border.

Method: a qualitative study, carried out with eight nurses who worked in hospital care, in a municipality located on the French-Brazilian border, between the months of October and November 2018. We used the semi-structured interview technique, recorded and transcribed, analyzed based on themes founded in the Theory of Care.

Results: two categories emerged: Knowing and being with the client, in which the reception and guidance were emphasized; Limitations to maintaining beliefs, doing for and making it possible, whose main limiting agents were the lack of specialization in obstetric nursing, precarious prenatal care, cultural diversity and teenage pregnancy.

Conclusion: employees highlighted the need of knowing the context in which they operate to support the care plan. Deficient autonomy, due to the lack of training, as a complicating factor for quality obstetric care was evidenced.

DESCRIPTORS: Obstetric Nursing; Border Health; Nursing Theory; Women's Health; Border Areas.

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PARTO E NASCIMENTO NA FRONTEIRA FRANCO-BRASILEIRA: PERCEPÇÕES DE ENFERMEIROS

RESUMO
Objetivo: compreender as percepções de enfermeiros sobre a assistência ao parto e nascimento hospitalar, na fronteira franco-brasileira.
Método: estudo qualitativo, realizado com oito enfermeiros que atuavam na assistência hospitalar, em um município localizado na fronteira franco-brasileira, entre os meses de outubro e novembro de 2018. Utilizou-se da técnica de entrevista semiestruturada, gravada e transcrita analisada de forma temática fundamentada na Teoria de Cuidados.
Resultados: emergiram duas categorias: Conhecer e estar com o cliente, em que se enfatizaram o acolhimento e as orientações; Limitações à manutenção de crenças, fazer por e possibilitar, cujos principais agentes limitantes foram ausência de especialização em enfermagem obstétrica, precariedade da assistência pré-natal, diversidade cultural e gravidez na adolescência.
Conclusão: os colaboradores evidenciaram a importância de conhecer o contexto em que se insere para alicerçar o plano de cuidados. A insuficiente autonomia, mediante ausência de capacitação, foi evidenciada como fator complicador para assistência obstétrica de qualidade.

DESCRITORES: Enfermagem Obstétrica; Saúde na Fronteira; Teoria de Enfermagem; Saúde da Mulher; Áreas de Fronteira.

PARTO Y NACIMIENTO EN LA FRONTERA FRANCO-BRASILEÑA: PERCEPCIONES DE LOS ENFERMEROS

RESUMEN:
Objetivo: comprender las percepciones de los enfermeros sobre la asistencia en el parto y el nacimiento en el hospital, en la frontera franco-brasileña.
Método: estudio cualitativo, realizado con ocho enfermeros que trabajaban en atención hospitalaria, en un municipio ubicado en la frontera franco-brasileña, entre los meses de octubre y noviembre de 2018. Se utilizó la técnica de entrevista semiestructurada, grabada y transcripta con análisis temático sobre la base de la Teoría del Cuidado.
Resultados: surgieron dos categorías: conocer y estar con el cliente, en las que se enfatizaron el acogimiento y las pautas orientativas; limitaciones para el sostenimiento de las creencias; fomentar y tornar posible, cuyos principales agentes limitantes fueron la ausencia de especialización en enfermería obstétrica, atención prenatal precaria, diversidad cultural y embarazo adolescente.
Conclusión: los empleados mostraron la importancia de conocer el contexto en el que operan para apoyar el plan de atención. La insuficiencia de autonomía, debido a la falta de capacitación, se evidenció como un factor que dificulta la atención obstétrica de calidad.

DESCRIPTORES: Enfermería obstétrica; Salud de frontera; Teoría de enfermería; Salud de la mujer; Zonas de frontera.

INTRODUCTION

Childbirth in Brazil has become an institutionalized, a medicalized event and strongly related to unnecessary interventions[1,2]. In contrast to this scenario, obstetric nursing is currently moving towards more comprehensive care based on scientific evidence, respecting the patient's autonomy and ethical care, with the adoption of interventions, at appropriate times, for the maintenance of maternal and newborn health[3-5].

For childbirth and birth to become safe events, it is necessary to offer quality services, comply with obstetric protocols and that health professionals exercise care practices based on the best scientific evidence[6,7].

In this sense, the availability and accessibility of health care in remote and faraway areas of urban centers are pointed out as deficient. For example, the diverse contexts of Amazonian borders are observed, in which there is a shortage of qualified professionals and health care is still precarious[8], which can compromise the maternal and neonatal health of the populations that live in this area, such as ribeirinhas, indigenous and other forest peoples.

As seen in other countries that are part of the Amazon context[8], it is observed that the states of Northern Brazil have a high proportion of obstetric complications[9]. It is also verified that complications among indigenous women are more frequent when compared to black and white women[10]. It is also observed that the state of Amapá, located in the extreme north of Brazil, has the second-highest maternal mortality rate in Brazil[11].

However, the literature is scarce regarding nursing care for childbirth and birth at this circumstance Thus, it is recognized the need to understand nurses' perceptions of hospital assistance for childbirth and birth, carried out in remote regions, such as the border region of the twin city of Oiapoque, located between Brazil and French Guiana.

One way to understand birth and childbirth assistance is through care models and theories that permeate the nursing professionals' practice. Theories can offer structure and organization to care, in addition to perspective on how to look at the patient's situation, while providing a systematic way to collect data[12].

Kristen Swanson's Caring Theory assesses that nursing actions and assistance must be established on individuals and, especially, on their capacities, enabling the eligibility of needs and priorities, based on the approach to the patient[13]. Thus, the framework of care is presented as a process interconnected to sympathy between the parties involved, in which the nurse assumes the feeling of responsibility towards the client, from the perspective of maternal health[14].

In addition to favoring the data analysis and interpretation, this theoretical perspective allows nurses to carry out the planning and implementation of care, systematically and intentionally[13]. Thus, the study aimed to understand the perceptions of nurses about childbirth and hospital birth assistance, on the Franco-Brazilian border.

METHOD

A qualitative study, developed in the only Brazilian hospital that serves the population of the border belt in the State of Amapá, Brazil, located in the municipality of Oiapoque, a reference in low and medium complexity care and that makes up the locality's *Rede Cegonha*.

The tertiary care closest to the municipality is in Cayenna, capital of French Guiana

and, in Brazil, in Macapá, 600 km from the municipality of Oiapoque. The road that connects Oiapoque to Macapá has a distance of 112 km that is not paved, making it difficult for vehicles to access it during periods of the Amazonian winter. This hospital has nine nurses. The physical structure for obstetric care has a delivery room, pre-delivery and an obstetric ward. On average, there are 300 annual deliveries, between vaginal and cesarean sections.

It was established as inclusion criteria: being a nurse, providing assistance in labor, delivery and puerperium and to the newborn in the elected hospital. Exclusion criteria were defined as: being away due to sick leave or vacation. The sample was of census type, only one nurse did not participate in the study, due to a premium leave during the collection period. Thus, eight assisting nurses participated.

The interviews were previously scheduled, held in a private room, with an average time of 30 minutes. The dynamics of hospital care were respected in order not to interfere with clinical and managerial activities. Data collection took place between October and November 2018, in the morning and evening periods.

Open interviews were conducted, using the following question: how do you perceive the practices performed in the care of childbirth and birth? The interviews were recorded and transcribed in full. Transcriptions were carried out within 24 hours after recording, for better recall. The statements were identified by the letter N (Nurse), followed by the numerical order of the interviews.

Sociodemographic data were collected using a structured form, with data on age group, sex, time since graduation, if the nurse attended a specialization course in obstetric nursing and/or residency in obstetric nursing, if the nurse attended *stricto sensu* training, length of experience in that service.

The arrangement for organization and analysis of qualitative data was performed according to the Content Analysis technique, following the three phases of this modality[15]. After full transcription of the interviews, float reading was carried out, which enabled the definition of the corpus to be analyzed. The analytical categories were grouped, according to the identification of common or related elements and characteristics about a concept, capable of representing it[15].

Kristen Swanson's Caring Theory was used for analysis, which is based on five basic processes that validate and offer meaning to care: knowing, being with, doing for, and making it possible and maintaining beliefs[13].

The project was approved by the Ethics Committee of the Federal University of Amapá, through opinion 2,980,053. To outline the study, the guidelines of the Consolidated Criterion for Qualitative Research Reporting (COREQ) were followed.

RESULTS

The nurses interviewed were in the age group from 27 to 55 years old, they were female. Graduation time ranged from four months to 20 years. None of the nurses reported having attended specialization and/or residency in obstetric nursing or had a *stricto sensu* graduate school. The time of experience in that service ranged from four months to 12 years.

In the analysis of the interview statements, two categories emerged: Knowing and being with the parturient woman; and Limitations to maintaining beliefs, doing for and making it possible.

Knowing and being with the parturient

The participants mentioned that it is the nurse's role to make the moment of birth and childbirth more pleasant and that welcoming is part of this duty, especially in assisting the primiparous women and in the context of teenage pregnancy:

It depends on how you welcome the patient. Because everything seems to be very scary, especially those who are first-time mothers and those who are young teenagers, when they arrive in the delivery room, they are a little scared, afraid, cold sweating, so, I realize that my role at that moment is to make that environment a little more pleasant. (N7)

It was found that the guidelines consisted of continuous concern, due to the peculiar characteristics of the population, in which the absence of complete exams and prenatal consultations or incomplete prenatal care, teenage pregnancy, low education, artisanal mining area, ribeirinhas population, indigenous culture:

There are some who come here and have only had two prenatal consultations or none; they are very young too, they are on average 14, 13 years old. This is a concern, I am always on the attentive to try to clarify doubts and guide care, it is difficult, you know? (N8)

In our reality, the majority of pregnant women, 90% do not do prenatal care, or if they do prenatal care, it's not complete, with less than three consultations, or it is that pregnant woman who may also come from mining, 'ribeirinha' or indigenous, and, in most cases, did not go to any consultation, no exam, so we try to assist this pregnant woman in the best possible way, through guidance at that moment, but many things have no solution. (N4)

Limitations to maintaining beliefs, doing for and making it possible

Nurses exposed limitations for performing an adequate practice, such as the restriction of positioning to give birth, the impossibility of choosing music for birth, the fear of measuring the cervical dilation and the presence of a companion. The main structural limiting agents were the precarious physical structure and materials, the lack of specialization in obstetrics, the waiting on medical consent:

So far, I have never seen a woman ask to listen to music. We always say that she has freedom, however, I cannot choose, because I am not the one who has the doctor. It depends a lot on the doctor. I can't tell a woman to squat if the doctor doesn't agree. I don't usually manage the delivery alone; I just help. I do not do the vaginal examination, because I have no specialization in obstetrics. I am very afraid .... If I had at least the training, I would be more secure. (N7)

Most births here are done by the doctor, we have an operating center and a table, where most births are performed there. This is our reality, which is still quite precarious for us to act safely. The pregnant woman has no choice, such as squatting or giving birth in the bathtub with water, which we see a lot today, that natural birth, where the pregnant woman enters the water and the father beside her, filming, this is not the reality of the public health service here in the state. I think most hospitals still don't work that way. We have no structure nor material. (N4)

The permission for the male companion was mentioned as difficult to be done by the participating nurses, since the researched institution has a rule that prohibits this type of stay in the female wards. However, the statements of the participants show disagreement and dissatisfaction with the regulations. besides, this practice depends on the doctor's authorization, as described in the following statements:

If there is a companion law, every woman has the right to it, regardless if it will be a man or a woman. Here, since they don't have wards for everyone, the excuse they gave me is that since they have other women, they would be uncomfortable with the presence of a man there. I respect in part, because it is my work environment, I have to accept it, but I, as a citizen, I do not agree! There are women who come here and have no mother, no sister, just a husband who has to go after a neighbor, someone to be with his wife, this is unnecessary!

If she doesn't have a husband, sometimes she has a father, a brother. Sometimes a pregnant woman arrives here with her husband saying right away: look, there is no one else! They have friends who, when they see the man inside, take them out of the room, saying that he can't stay. When I'm on duty, I might even hear from the boss later, but I let him in! (N1)

Not doing, or, doing ineffective prenatal care leads to misinformation. The arrival of the parturient in the expulsive period of childbirth, often because of the geographic isolation of the indigenous villages, was mentioned as a complicating factor, due to the absence of exams during the prenatal period or the absence of prenatal care.

The cultural diversity in the region was also pointed out as an obstacle. Since many indigenous peoples, of different ethnicities and foreigners coexist, with little fluency in Portuguese, or poor knowledge of this language, effective communication and care for the real needs of the parturient are hampered. Teenage pregnancy was also mentioned as a constant in obstetric care.

Often, there is no exam, you know? When this is the case, I already consider a high-risk pregnancy. Because of the lack of prenatal care. Another very serious thing in the municipality is teenage pregnancy. We have many girls here, 13, 15 years old, pregnant and without any psychological preparation. Totally inexperienced, unprepared, so I try to focus my attention on them, with directions. We provide care for many indigenous people, they often arrive after the expulsion period, they come from the villages, they arrive very late. So, it is already a very serious problem for us. Sometimes, with only one or two prenatal consultations, without any exam; it's like, almost arriving for childbirth, so this becomes a problem for us. I always say that this is concerning! Because we don't know anything about the pregnant woman and, many times, even the language factor, the cultural difference also gets in the way. [...] It is a great problem in the municipality, since prenatal care, but here it is making a difference with good guidance. (N6)

DISCUSSION

The reception of the user enables knowledge of parturient and plays an important role in building a bond of trust with health professionals and services, which favors the role of women during labor[16]. The concern with the context in which the clientele is inserted and the concern in carrying out the welcoming and the guidance, observing the specificities, shows the basic processes of Kristen Swanson's Caring Theory, which have, in this sense, the techniques of knowing and being with.

The precariousness of physical structure was mentioned as a complicating factor in the performance of nursing activities in other studies[17,18]. The absence of exams, consultations or incomplete prenatal care of the clientele was pointed out as adversity in providing quality care to the parturient and the newborn.

In this sense, the nurses declared that it is common the parturient arriving in the hospital unit without prenatal care or an insufficient number of consultations, as recommended by Rede Cegonha[19]. This fact agrees with that verified in some health surveys, in which the Northern Region of Brazil had the worst scores of the *Programa de Melhoria do Acesso e da Qualidade* (Program for Improving Access and Prenatal Quality)[20-22]. The *Nascer no Brasil* (Birth in Brazil) survey also found that inadequate prenatal care, as well as women who lived in the North Region and those who were left without companions during hospitalization, had a high neonatal mortality rate[21]. This region was also the one that underwent the least ultrasound examination during prenatal care[22].

Another aspect listed was the lack of specialized knowledge in the area of obstetrics by the nurses. The lack of expertise generates insecurity in obstetric practice, which contributes to professionals losing autonomy and contributing to subordination to the doctor in the scenario of childbirth care in the hospital environment[22].

The education corroborates with the increase in nursing autonomy in obstetric practice[22] and its absence, with difficulties in providing the birth process centered on the parturient. Studies point out that the obstetric nurses' assistance to pregnant women at usual risk is associated with lower rates of unnecessary interventions, less risk of episiotomy and delivery using birth tools, a greater chance of spontaneous delivery and a greater feeling of control by the parturient[3-5]. There is also a greater possibility of starting early breastfeeding and a shorter neonatal hospitalization[5].

Deficient working conditions and the low opportunity for promotion and professional education are factors that hinder the establishment of health professionals in remote areas of large urban centers and of extreme social vulnerability[16,23]. The North and Northeast Regions have the most unequal situation in the country, regarding the distribution and settlement of these professionals[16,23].

Furthermore, it was considered as a limiting factor for safe assistance to recurrent adolescent pregnancy by the clientele. In this sense, adolescents are more likely to have complications, with greater probabilities of premature placental displacement, premature birth, biopsychosocial changes, postpartum depression, among others[24-26]. Maternal age less than 20 years has a greater possibility of neonatal mortality[21,26].

Cultural diversity has been referred to as a limiting factor to effective communication, in which there are various indigenous ethnicities, in addition to foreigners, and the spoken language is often a barrier to communication between the pregnant woman and the professional. From this perspective, it is observed that the indigenous Karipuna, Galibi and Palikur from Oiapoque have different traditions and cultures. The Galibi speak the language of the Karib family; the Palikur, an Aruake native language; and the Karipuna speak patoá, a Creòle dialect of French Guiana. Portuguese is known by men and, less frequently, by women[27].

Regarding the dialect, it is observed that linguistic variation becomes a limiting factor for a reliable understanding of what the patient reports about her own health, even though there is a translator[28]. The difficulty of full translation sometimes results in misunderstandings, getting caught by words that do not exist in the other language, given the technical vocabulary of the health field and the dialect in question[28].

Pregnant women from *riberinha*, artisanal miners and indigenous people were also listed, since they live in locations far from urban centers and with difficult access to hospital care. According to the interviewees, these pregnant women do not perform prenatal care and arrive at the hospital, often in the expulsive period of childbirth, which makes the anamnesis and the offer of safe assistance difficult. This aspect has also been addressed in other studies[9,10].

Confirming to the above, it is verified that the presence of Maternal Near Misses in indigenous pregnant women is high[9,10], a condition attributed to the fact that these women live in locations far from hospital centers, and, thus, resulting in delay to begin adequate hospital care[9,10].

The main elements involved in the delay of care involve include the decision to seek health services, the delayed arrival at the health unit and the delay in providing care at the reference institution[27]. Timely access could reduce maternal morbidity and mortality[29,30].

In this perspective, f indigenous and *ribeirinha* peoples in geographic isolation, with a large number of streams and the absence of road paving; broad territory with low population density; harsh winter that makes air traffic impossible, can act as conditioning factors that hinder access to health services for women who have severe maternal morbidity.

Given the above, this study presents as a limitation, the generalization of the findings. However, despite this restriction, the investigation presents preliminary results on obstetric nursing care in remote areas, thus raising the importance of future investigations on the theme of specialized professional education and its connections with the reality of obstetric

care provided to the population. The study presented is an example not only of the specific reality analyzed, but is inserted as a model of a broader context, experienced in remote pan-Amazonian areas.

FINAL CONSIDERATIONS

The perceptions about childbirth and birth assistance by the participating nurses recommended the stages of getting to know and being with the pregnant woman, emphasizing the welcoming and guidance to the clientele. The limitations were mentioned in the context of maintaining beliefs, doing for and making it possible, in which the lack of specialization in obstetric nursing resulted in little autonomy for the care of parturient, puerperal and newborn.

The lack of, or unsatisfactory prenatal consultations was mentioned as an obstacle to safe care. The precariousness of the physical structure and human resources, which makes it impossible for postpartum women and parturient in different wards, were mentioned as a complicating factor in the exercise of good practices in childbirth and birth.

The cultural diversity of the peoples of the forest was mentioned, which hinders the processes of effective communication between the team and the patient. The great distances of villages and rural communities hinder the provision of safe nursing care. Adolescent pregnancy was considered as another aggravating factor, since adolescents are more likely to obstetric conditions.

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