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EVALUATIVE STATEMENTS OF ESCORTS ABOUT THE CARE PROVIDED TO WOMEN

ENUNCIAÇÕES AVALIATIVAS DE ACOMPANHANTES SOBRE O CUIDADO PRESTADO À MULHER

DECLARACIONES EVALUATIVAS DE ESCORTS ACERCA DE LA ATENCIÓN PRESTADA A LAS MUJERES

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Objective: describing the evaluative statements of escorts about the care provided to women in the process of birth. Method: a descriptive research with qualitative approach performed with ten escorts in a maternity school. The semi-structured interview was used as a data collection technique. For the treatment of the statements, the Thematic Content Analysis Categorial was used. Results: the content obtained was systematized into two categories: evaluative statements related to health services and evaluative statements related to the care provided to women in the process of birth. Final thoughts: the escorts enunciated and experienced the care provided many times as limited and associated with the workload of the professionals; however, they reinforced the reception and communication as important.

Descriptors: Formal Escorts in Physical Examinations. Parturition. Health Services. Health Personnel. Health Assessment.

Objetivo: descrever as enunciações avaliativas de acompanhantes sobre o cuidado prestado às mulheres em processo de parto. Método: pesquisa descritiva com abordagem qualitativa realizada com dez acompanhantes em uma maternidade escola. Utilizou-se a entrevista semiestruturada como técnica de coleta de dados. Para o tratamento das falas, empregou-se a Análise de Conteúdo Temática Categorial. Resultados: o conteúdo obtido foi sistematizado em duas categorias: enunciações avaliativas relacionadas aos serviços de saúde e enunciações avaliativas relacionadas ao cuidado prestado às mulheres em processo de parto. Considerações Finais: as(os) acompanhantes enunciaram e vivenciaram o cuidado prestado muitas vezes como limitado e associado à sobrecarga de trabalho dos profissionais, entretanto reforçaram o acolhimento e a comunicação como importantes.

Descritores: Acompanhantes Formais em Exames Físicos. Parto. Serviços de Saúde. Pessoal de Saúde. Avaliação em Saúde.

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Objetivo: describir las declaraciones evaluativas de los acompañantes acerca la atención prestada a las mujeres en el proceso de parto. Método: se trata de una investigación descriptiva con enfoque cualitativo realizada con diez acompañantes en una escuela de maternidad. La entrevista semiestructurada se utilizó como técnica de recopilación de datos. Para el tratamiento de las declaraciones, se utilizó el Categorial de Análisis Temático de Contenido. Resultados: el contenido obtenido se sistematizó en dos categorías: declaraciones evaluativas relacionadas con los servicios de salud y declaraciones evaluativas relacionadas con la atención prestada a las mujeres en el proceso de parto. Consideraciones finales: los acompañantes enunciaron y experimentaron la atención prestada muchas veces tan limitada y asociada con la sobrecarga de trabajo de los profesionales, sin embargo, reforzaron la recepción y la comunicación como importante.

Descriptores: Compañeros Formales en Exámenes Físicos. Parto. Servicios de Salud. Personal de Salud. Evaluación de la Salud.

Introduction

The presence of the escort during the labor and birth process has always been an event experienced by women throughout history, when this was still an intimate experience that occurred in the family environment. This event had the support of other women, who provided the parturient with a comfortable experience[1].

With the institutionalization of childbirth, intense medicalization and surgical interventions became part of the parturition scenario. Therefore, the hospitalization of this rite of passage, which was experienced in the domestic sphere, resulted in a greater distancing from these people more intimate to the woman from the birth scenario[2]. Although scientifically confirmed the importance of social and continuous support in the birth process, for a long-time woman experienced the pain and vulnerability of being without this support, and this escort were deprived of experiencing, from their perspective, this moment in a singular way[3].

The continuous support during this process affects the experiences of the woman and the result of birth. Thus, health professionals, especially obstetric nurses, should seek strategies to reinsert the escort in the birth and labor scenario, so that she can actively act in this process and, thus, enable benefits to the woman. In addition, these people, by allying with the work of the Obstetric nurse, can enhance the care provided and generate a positive impact on the work process of this professional[4-5].

The Ministry of Health recognizes the benefits brought by the presence of the escort and that pregnant women who have this participation in childbirth and immediate puerperium are calmer and safer during the process. To ensure the presence of this person chosen by the woman, Law n. 11,108/2005, known as the Escort's Law, was sanctioned in Brazil[6]. Although the presence of an escort is guaranteed by the legislation, obstacles to their participation are observed in some health services, justified by inadequate infrastructure and, mainly, by the lack of preparation of the health team about the law[7].

Evidence indicates that the presence of an escort can have a protective effect, hindering the excess of interferences and procedures, often unnecessary and even harmful in the parturition process, as well as reducing the acts of obstetric violence by the care team[4]. In this perspective, the presence of a figure known by the woman stimulates a more cordial relationship on the part of the assistance team. Moreover, it also brings support benefits in labor and birth for perineal outcomes, such as, for example, shorter duration of labor and proportion of cesarean sections, as well as less use of analgesia[4-8].

In this scenario, it is observed that this situation reverberates in the evaluation of women and escorts about health services and the care provided by professionals in hospital institutions, as well as in the impacts of this care for the professional himself[1]. Studies point to the growing trend for health assessment research, especially about the evaluation of the effects of specific policies, such as health policies for women, especially from the perspective of service

users. This may allow the intervention on real problems presented by this population segment, as well as for the construction of strategies for the maintenance of escorts of these women in the scenarios of labor and birth[7].

The evaluation, from the perspective of health professionals and service users, is considered a significant element in the development of care and management processes. However, the evaluation by female escorts about the care that is provided in institutions is little reported and prioritized within public health policies, especially in maternity[5]. However, even though today they are already present in the scenario of institutionalized childbirth and supported by the law, these social actors are not supported by actions that improve their permanence in health services.

In this sense, through the results of studies that evidence these evaluative characteristics, especially those that demonstrate the perspective of escorts, it is possible to reorganize health services to meet the demands of these users who integrate women's health care strategies and policies in the Unified Health System, with a view to improving the care provided. Thus, in view of what is recommended for the daily life of the institutions that serve the parturient and what is experienced by her and her social support, the aim of this study is to describe the evaluative statements of escorts about the care provided to women in the process of childbirth.

Method

Descriptive study with qualitative approach. Held in a maternity medium-sized school located in the city of Salvador, Bahia, Brazil, with escorts of women in the process of birth.

The participants were selected through the list of escorts present at the institution at the time of the visits and who agreed to participate in the research. It was adopted as inclusion criteria for escorts of women who were hospitalized in the process of birth and may be familiar or not and who had followed throughout this process. Exclusion criteria were an escort who did not have physical and/or emotional conditions declared to the researcher to participate in the research. The acceptances totaled 11, however the sample of this study was composed of 10 escorts, due to the exclusion criterion.

The maternity hospital where the data collection took place is a teaching-care unit of Obstetrics, Neonatology and Perinatal Health. It is considered a medium-sized hospital, a specific type of medium complexity, with 80 beds. It performs an average of 250 deliveries and more than 6,000 outpatient procedures per month. The unit provides emergency obstetric and neonatal emergency services 24 hours a day, offering 24-hour Care with Risk Classification of patients from the outpatient clinic of the institution and the State Regulatory Center of the state of Bahia. As a reference for high-risk prenatal care, it also provides vacancies for the network aimed at women living in cities in the Metropolitan Region of Salvador (MRS) and the countryside of Bahia.

The Maternity has a multidisciplinary team and offers outpatient and hospital care in Cardiology, Medical Clinic, Physical Education, Endocrinology, Gynecological Endoscopy, General Physiotherapy, Physiotherapy in Women's Health, Speech Therapy, Medical Genetics, Gynecology, Hematology, Mastology, Fetal Medicine, Neonatology, Neuropediatrics, Nutrition, Obstetrics, Ophthalmology, Psychology, Psychiatry, Social Work and Occupational Therapy, among other services to support the health care of women and children. It also has a Neonatal Intensive Care Unit (NICU), Conventional Neonatal Intermediate Care Unit (CNICU) and Kangaroo Neonatal Intermediate Care Unit (KNICU), Human Milk Bank (HMB) and Pregnant Woman's House, Baby and Puerperium (PWHBP).

Data collection occurred between August and November 2018 during visits by the researcher who conducted the interviews at the institution. The interviews were closed, based on the criterion of data saturation, in the tenth interview. The delimitation of the number of interviewees occurred when the content was sufficient to allow the deepening, scope and

diversity of the process of understanding the statements described. The semi-structured interview had objective questions regarding the characterization of the participants, in addition to the following guide question: How was it for you to experience the birth labor process?

The interviews were conducted in private rooms in the maternity hospital itself, at times previously scheduled according to the availability of the participants, being recorded with the help of a smartphone and had an average duration of 40 minutes. After this stage, the interviews were transcribed in full and received abbreviated identification codes, in which the letter "E" refers to "Interview" followed by the Arabic numeral corresponding to the order of the performance (E1, E2, E3, etc.), to preserve the anonymity of the participants.

The data were organized based on the Thematic-Category Content Analysis proposed by Franco[9]. Thus, the statements were submitted to the unitarization process, which required a rereading of the messages attributed to the object of study, favoring the identification and definition of the units of analysis (concepts phrases, themes or words). These were aggregated into record units and later into context units.

The participants' statements were analyzed under the theoretical assumptions of the current ministerial regulations and laws, which allowed the identification of the categories of analysis. From the statements of these escorts emerged their experiences and the evaluative statements about the care provided to women in the process of birth. The findings were relevant and original for the research and for the analyses that allowed them.

The study had the institution's consent and was developed after consideration and approval of the research project by the Ethics and Research Committee (CEP) of the Climério de Oliveira Maternity Under Opinion n. 2320722. In addition, it complied with the guidelines and norms of Resolution n. 466/2012 of the National Health Council, which regulates research involving human beings. All participants were informed about the study and signed the Free and Informed Consent Form (FICF). They were also informed of the measures to ensure anonymity and confidentiality of the data obtained.

Results

Ten escorts of women in the process of birth participated in the study, seven men and three women. Of these, six were between 18 and 34 years old and four were between 35 and 59 years old. Regarding the degree of kinship, the men declared marital relationship and between the three women, two were the mother and one, the sister. All participants declared themselves black (black and/or brown).

The statements of the escorts were grouped into two categories: Evaluative statements related to health services and evaluation statements related to the care provided to women in the process of birth labor.

Evaluative statements related to health services

In the evaluative statements of the escorts of women in the process of birth, the lack of capacity of health services in the public sphere was mentioned compared to the services offered in the private network. The escorts blamed the government for the lack of investments:

> *Some hospitals do not have the capacity to serve many people, this is complicated. My wife was very afraid that we had not thought before about having made a health plan and now we are faced to go to the SUS. I believe it's the government's fault for not making investments.* (E1).

The statements suggest that the capacity of care in health services is associated with the process of overcrowding in the units. This workload in the services has kept the escorts away from the childbirth process and generated fear. In parallel, they felt safe when there was an adequate structure and accountability of the service for the patient. However, they mentioned the care, by the institutional structure, of the basic needs of the escorts in line with the patient's safety, as well as the importance of offering information on the location of the sectors:

> *There was no vacancy in the maternity ward. So, the professionals took responsibility for regulating my sister. They got the job at another hospital, so it went well.* (E10).

> *At the other hospital we were in was an embarrassing moment, carnage. The escort could not enter and know how the woman is because of overcrowding. It's hard to keep up with a woman's birth. I was very scared, but when they referred my daughter to this hospital, I felt safe. Here is a wonderful structure! The bathroom, the appliances all good, but there should be indication of where the places are, the cafeteria, the bathroom.* (E9).

> *The bath of the escort must be discussed. We were on the street and now we've been in the maternity ward since we got here without showering. We want to refresh ourselves and still have the issue of bacteria.* (E8).

The evaluative statements of the escorts attributed the best care offered in the health service of the capital when compared to the care provided in the interior of the state. They referred to the moment of transport as embarrassing and uncomfortable:

> *It was a complicated birth; it was difficult for the baby to leave. She just didn't die because she was transferred from the country to the capital. I thank you very much for the service.* (E3).

> *The professionals did all the correct procedure. There was no intercurrence. I witnessed the care with the patient, the child and liked it.* (E10).

> *I thanked God for allowing my daughter to arrive at the capital's maternity ward. On the trip, the ambulance shook, and it was very embarrassing. Her with that big belly, feeling pain, without any comfort. (E2).*

Evaluative statements related to the care provided to women in the process of childbirth

The statements enunciated people without conditions and despised in the care process. The escorts shared moments of tension about the professional's experience with work workload, when attending women who arrived stressed in health services and transferred to the professional all the emotional burden of the moment:

> *It's the first time I've seen people without conditions being scorned. It is a very great tension for the health professional who serves a lot of people and with various problems. People arrive stressed, take it out on the professionals, and these, workloaded, end up not being respected in the health service. I don't think that's right. You must think on both sides: the professional and the patient.* (E1).

The following statement shows appreciation of the escorts for the reception provided by professionals, however they reported discomfort, due to the high number of students and questions at the time of birth. The escorts attributed the presence of many students to the fact that it is a common routine in a hospital:

> *In the maternity ward, she was well received by the medical and nursing staff. They were all great! I don't have anything to complain about, but I found it uncomfortable for the person to be in pain with the room full of interns. A student asked my daughter many questions; she didn't want to say anything. She was in a lot of pain and wanted to ask the student to leave, but it's a hospital.* (E2).

The statements revealed the importance of professionals listening to women and being present in the childbirth process. The absence of these may generate lack of care and fear, in the view of the escorts:

> *At the time I wasn't there, my wife reported that the nurses said she was making a scene. I wanted to tell them to listen to the patient because that's important.* (E5).

> *I was alone with my wife and it soon came to my mind that the doctors and nurses didn't want to help at that time. I was afraid she'd faint because they were at the front desk. Despite this, they were always watching, going in and out of the room to see how she was.* (E4).

The escorts reported that care for pregnant women at risk could be better from the diagnosis of the complication to the transfer to the hospital. At the time of birth, the escorts felt useless in the presence of the team:

> *The assistance could have been better, since she was a pregnant woman at risk. I don't quite understand. It was diagnosed in the outpatient clinic that the baby's heart was low. I think they should have arranged a car right away to transfer her to the hospital. But at the time of birth, the team was very present and at that moment I felt a useless person.* (E7).

The escorts praised the communication of health professionals and reported their participation in the birth labor process as an opportunity for knowledge regarding the care and procedures provided by professionals:

> *I liked the care of this maternity and the professionals. Everybody talks to us. Doctors and nurses pass by, greet with good morning, even for those who do not know.* (E3).

> *It is good when the professional arrives for the escort and explains when the birth is taking time, or why he did not have a cesarean section. It is important to hear from professionals who are seeking the best for the patient and the child. I watched this all the time.* (E10).

> *This is the first time I've participated in a birth process. It was important for me to see how care is, how the child is born, how professionals work and know the procedures.* (E6).

Discussion

About practical applicability, it is perceived that the insertion of the escort in the childbirth scenario, as prescribed in the law, allowed a differentiated look at this one who is a user of the services and experiences the birth process from another perspective, not only that of spectator, but also of evaluator.

The evaluative statements of the accompanying statements of women in the process of childbirth revealed how the lack of investments has repercussions in the health sector, especially in public institutions and in work processes. This contributes to the precariousization of the public health service, which is strengthened with government initiatives to reduce health resources[10]. In view of situations such as this, the approval of the Proposed Constitutional Amendment in 2016 allowed the freezing of state investments in health for 20 years, which disagrees with the needs of the population and the guidelines of the Unified Health System (SUS)[11].

The escorts, in their evaluative statements, when comparing the services provided in the public and private spheres, reflected on the inability of the offer in public services. This finding is based on the reality of underfunding and poor distribution of resources that accelerate precariousization in the SUS. This situation has fueled, in the imaginary of society, the understanding that there is greater competence in the investments of the private sector in the health sector. This, however, can politically enable the emergence of proposals for co-participation or insertion of private capital in the SUS and contribute to privatizations and the commodification of health[12-13].

The differences between public and private health services have generated insecurity in the accompanying ones, when using the services provided by the SUS. This situation may occur due to the tendency of the population to value the health services provided by the private network as more qualified, based on access to health plans[13].

This understanding was verbalized in the statements of the escorts in situations that generated fear and embarrassment in the face of overcrowding in public services. The result of a study on public health expenditures showed that the escorts blamed the government for the overcrowding of public maternity hospitals, the absence of vacancies and, consequently, the work workload for health professionals[10].

The problems arising from overcrowding in public maternity hospitals in Brazil are increasing. This has often caused the publicization of complaints about the difficulties faced by parturient women in public maternity hospitals, especially about the insufficiency of beds, professionals and precarious physical facilities for childbirth and birth care[14].

This insufficiency in the supply of beds, materials and human resources becomes notorious, for example, in requests for the transfer of parturients from health units in the interior to the capital. Due to the organization in the supply and distribution of obstetric beds, there is greater availability of these services in large urban centers, where greater technological contribution and more skilled human resources are also concentrated[15].

Among the health services that structure women's care, transportation stands out. The escorts mentioned the insecurity in ambulances, during the transport of women in labor from the interior to the capital and praised the possibility of transferring the woman to maternity hospitals that had quality in the structure, in material resources and allowed the presence of an escort. This reality has contributed to the overcrowding in the hospital units of large centers and confirms the trend of the current policy of structural adjustment of the State, which has reflected in investments for health[10,15].

The escorts revealed, in their statements, the importance of the adequate physical structure in maternity hospitals, mainly related to the supply of insumnas and bathrooms, which implies the satisfaction of users. A study conducted in the city of Recife (PE) on the quality of birth care in the public hospital system revealed that user dissatisfaction was more related to the ambience of maternity hospitals[15]. However, the structuring of the obstetric network is a problem for

maternity hospitals, since, in addition to causing overcrowding of the service, care demands and, consequently, work workload for professionals increase, which has affected the health of these individuals[16-17].

Brazilian research addresses work workload because of the increase in care and administrative demands, which hinder the planning and execution of care actions to be provided. This excess in the normal workload, both physical and psychic, added to the forms of work organization, can directly reflect on the lives of professionals and in losses in the care provided to women, contributing to dissatisfaction[14,18]. This excessive burden may be more intense for nursing staff because they participate in direct patient care and act on the front line of this care[19].

The work workload of health professionals may favor the permanence of many students in the birth scenario, since being workloaded in their care, administrative and even preceptorship functions, they cannot adequately welcome and guide students in training within the service. This fact can impact the formation of students, leaving them exposed to the development of unfavorable care practices[19-20]. In this sense, the escorts reported discomfort with the large number of students present in the childbirth scenario, inquiring the parturient women at inopportune moments and causing embarrassment for the women, because they felt invaded in their privacy.

This situation allows us to ponder the academic background based on the valorization of technical standards in obstetrics. However, what is the case is a teaching-learning process that needs to be based on the particularities and needs of the woman and her escort. Thus, health professionals would need to learn, in their education, that childbirth is a natural event and should have its physiology respected through beneficial, humanized and scientifically proven practices.

Regarding the feelings at the time of birth, the escorts reported feeling useless in a situation of obstetric complications. This sensation may be related to the perception of not belonging to the scenario together with the woman and/or not feeling integrated by the health team[19]. This removal, besides provoking unpleasant feelings, is configured as a violation of the right guaranteed by law[8]. Nevertheless, the escorts understands the relevance of her presence at the time of birth, as well as the need for knowledge about procedures and health care.

It should be noted that the research participants valued, in their statements, the communication directed to them by the professionals, which can favor the fulfillment of their specific demands in the condition of users of health services. In this sense, it is important to highlight the actions proposed by the National Humanization Policy, among which we highlight the valorization of listening, bonding and affective relationships in the practice of health professionals. Such actions facilitate the process of communication with users of the services, so that the information can be seized without flaws, doubts or even non-understanding[14]. For this reason, communication represents an important tool to improve health care. It is noteworthy that the quality of communication between health professionals and users will depend on the availability of the professional to establish this communication with the other[20].

Communication, therefore, favors the proximity between people and, particularly in the environment of childbirth, is established between professional and woman. The participants of this research revealed fear and considered lack of care when professionals were not accompanying the woman throughout the childbirth process. A study conducted in the state of Paraná, Brazil, in 2013, with 11 women and 11 escorts, showed the importance of having health professionals available and assisting care when requested. Moreover, aspects such as care, mood, bonding, availability of help, breastfeeding support and care for the baby were evaluated positively in view of the care provided to women in the process of birth[8].

This research allows an expansion of the views of women's health policies and their applicability in practice, as well as contributes to more visibility for this actor so important in the

birth scenario. However, there are few situations of listening and speaking of the escort. The study presented limitations regarding the content of the speeches, number of participants, since they bring with them family, social, cultural and gender characteristics. In addition, the research was composed of escorts from a maternity school, a fact that allows suggesting assessments of the reality of this institution in relation to the care received in the service and by health professionals.

Final thoughts

The findings of this study allow us to affirm that escorts of women in the process of birth labor refer to the care provided often limited due to the work workload of professionals. These social actors enunciate the tension of experiencing this moment with women, however they reinforce the appreciation for the welcoming provided at the time of the meeting. Some feelings, such as discomfort, together with the excess of professionals and students in the scenario of labor and birth, as well as feelings of uselessness in the face of obstetric complications, apart from the participants' statements. The research also demonstrated, through the enunciations of the escorts, the need for better physical structuring of the spaces with a view to promoting a welcoming to them as well. It is important to highlight that one of the results mentioned was satisfaction when the professionals communicated with the woman and the escort and were present at the birth, assisting the woman throughout the process. However, more research on escorts of women in the process of childbirth is necessary to enable reformulations of actions to be developed based on evidence and to ratify the importance of more humanized professional conduct in the childbirth scenario.

Collaborations:

1 – conception, design, analysis and interpretation of data: Keury Thaisana Rodrigues dos Santos Lima, Telmara Menezes Couto and Patrícia Santos de Oliveira;

2 – writing of the article and relevant critical review of the intellectual content: Keury Thaisana Rodrigues dos Santos Lima, Jaqueline Alves Pires, Patrícia Santos de Oliveira, Laís Teixeira Silva Almeida, Aiara Nascimento Amaral Bomfim and Daiane Teixeira Soares;

3 – final approval of the version to be published: Keury Thaisana Rodrigues dos Santos Lima.

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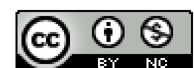

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