





ASSISTANCE TO WOMEN SUBMITTED TO CESAREAN SECTION DUE TO AN ARREST DISORDER

ASSISTÊNCIA PRESTADA ÀS MULHERES QUE FORAM SUBMETIDAS À CESARIANA POR PARADA DE PROGRESSÃO
ATENCIÓN A MUJERES SOMETIDAS A CESÁREA POR PARADA DE PROGRESIÓN

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ABSTRACT

Objective: to know the perception of women undergoing cesarean section due to labor arrest disorder on the care provided at a university hospital in southern Brazil. **Method:** this is a qualitative and descriptive study, through semi-structured interviews with 13 mothers who underwent cesarean section due to the labor arrest disorder. The data collection period was from August 1st to September 30th, 2017. The collected data were analyzed using thematic analysis procedures. **Results and discussion:** the categories emerged were fragmented care during labor, good practices in caring for parturients and the preference for the type of delivery and the referral for cesarean section. The data showed that the care provided at the obstetric center is fragmented, performed by several professionals. The best practices for the humanization of childbirth identified were: emotional and physical support and non-pharmacological pain relief methods, most often performed by the obstetric nurse. Most women had a preference for normal delivery in pregnancy, but underwent cesarean section and considered their labor a process that required intervention because of their body failure in the evolution of labor. **Final considerations:** in the perception of women, the obstetric nurse stood out in the team professionals in the care of labor, but this care was not configured as continuous support. The qualification of the professionals of this maternity hospital is recommended for the humanized and integral assistance to the needs of the parturients.

Keywords: Cesarean Section; Nurse Midwives; Labor, Obstetric.

RESUMO

Objetivo: conhecer a percepção das mulheres submetidas à cesariana por parada de progressão do trabalho de parto sobre a assistência prestada em um hospital universitário do sul do Brasil. **Método:** qualitativo-descritivo, por meio de entrevistas semiestruturadas com 13 puérperas que realizaram cesariana por parada de progressão do trabalho de parto. O período de coleta de dados foi de 1o de agosto a 30 de setembro de 2017. Os dados coletados foram analisados por meio de procedimentos de análise temática. **Resultados e discussão:** as categorias emergentes foram assistência fragmentada durante o trabalho de parto, boas práticas no cuidado às parturientes e a preferência da via de parto e o encaminhamento para a cesariana. Os dados mostraram que a assistência prestada no centro obstétrico é fragmentada, realizada por vários profissionais. As boas práticas para a humanização do parto identificadas foram: apoio emocional e físico e métodos não farmacológicos para alívio da dor, na maioria das vezes realizados pela enfermeira obstetra. A maioria das mulheres tinha a preferência pelo parto normal na gestação, porém foram submetidas à cesariana e consideraram seu trabalho de parto um processo que necessitou de intervenções pela falha do seu corpo na evolução do trabalho de parto. **Considerações finais:** na percepção das mulheres, a enfermeira obstetra se destacou entre os profissionais da equipe, no cuidado no trabalho de parto, porém esse cuidado não se configurou como suporte contínuo. Recomenda-se a qualificação dos profissionais dessa maternidade para a assistência humanizada e integral às necessidades das parturientes.

Palavras-chave: Cesárea; Enfermeiras Obstétricas; Trabalho de Parto.

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RESUMEN

Objetivo: conocer la percepción de las mujeres que se sometieron a cesárea debido a parada de progresión acerca de la atención brindada en un hospital universitario del sur de Brasil. **Método:** estudio cualitativo y descriptivo, a través de entrevistas semiestructuradas con 13 mujeres que se sometieron a cesárea debido a parada de progresión en el trabajo de parto. La recogida de datos se realizó entre el 10 de agosto y el 30 de septiembre de 2017. Los datos recogidos se analizaron mediante procedimientos de análisis temáticos. **Resultados y discusión:** las categorías emergentes fueron: la atención fragmentada durante el parto, las buenas prácticas en el cuidado de las parturientas y la preferencia por el modo de parto y la derivación a la cesárea. Los datos mostraron que la atención brindada en el centro obstétrico está fragmentada, realizada por varios profesionales. Las mejores prácticas para la humanización del parto identificadas fueron: apoyo emocional y físico y métodos no farmacológicos de alivio del dolor, realizadas generalmente por la enfermera obstétrica. La mayoría de las mujeres preferían el parto normal durante el embarazo pero se sometieron a cesárea y consideraron su trabajo de parto como un proceso que requirió intervención debido a falla corporal en la evolución del trabajo de parto. **Consideraciones finales:** en la percepción de las mujeres, la enfermera obstétrica se destacó entre los profesionales del equipo en la atención durante el trabajo de parto, pero esa atención no se configuró como un apoyo continuo. Se recomienda la calificación de los profesionales de la maternidad de este hospital para la asistencia humanizada e integral a las necesidades de las parturientas.

Palabras clave: Cesárea; Enfermeras Obstétricas; Trabajo de Parto.

INTRODUCTION

The cesarean section rate of Brazil in recent decades has grown significantly, reaching 56% of births. In the public service, this rate represents 40% of assistance and 85% in the private network.¹ In other countries, this rate is also growing, reaching 22% of births in the United Kingdom, 30% in Australia and the United States, and 38% in Italy.² According to studies and recommendations from the World Health Organization (WHO), cesarean section rates with more than 10% do not contribute to the reduction of maternal, perinatal and neonatal mortality.³ Considered as a serious public health problem, the increase in cesarean sections is associated with more risks to postpartum health, prolonged and painful recovery. Surgery leaves a permanent scar and many women realize that non-vaginal delivery has no benefit for bonding the mother to the newborn.^{4,5}

The increase in births by cesarean section may be associated with the transformation of the birth process, from leaving home and dominating traditional midwives to the hospital environment, giving the role of the women to the doctor, who in most of the time intervenes in this process.⁶ This “medicocentric” care model did not significantly reduce maternal and neonatal mortality from preventable causes.⁷

The *Ministério da Saúde* (BR), with the creation of the *Rede Cegonha* in 2011, proposed goals for humanization childbirth with the implementation of practices that support safe normal childbirth and the role of women in the pregnancy-puerperal cycle.⁸

The indications for a cesarean section are classified as absolute and relative. The absolute indications are absolute disproportion of maternal pelvis size, chorioamnionitis, maternal pelvic deformity, eclampsia or HELLP syndrome (hemolysis, elevated liver enzymes, low platelet counting), fetal asphyxia or fetal acidosis, umbilical cord prolapse, placenta previa, anomalous fetal presentation, and uterine rupture. The relative indication is the labor arrest disorder.^{4,9}

Measures such as continuous support to pregnant women in labor, the second professional opinion for the decision of a cesarean section, the appropriate use of the partogram and not performing continuous intrapartum fetal monitoring (in low-risk pregnancies) reduce the incidence of cesarean sections, especially those happening during labor.¹⁰ Continuous support is most often provided by the obstetric nurse, including the bonding with the parturient, the use of non-pharmacological pain relief methods, the emotional support, and the redemption of women.¹¹ This follow-up of the parturient women can develop the physiological process of birth and increase the sense of control and competence of these women, reducing the need for obstetric interventions in the labor arrest disorder.^{12,13} According to the *Diretrizes Nacionais de Assistência ao Parto Normal*, the care provided by the obstetric nurse in labor brings more satisfaction to women and reduces unnecessary obstetric interventions and cesarean sections.¹³

Therefore, this study aims to know the perception of women who underwent a cesarean section due to labor arrest disorder on care provided at a university hospital in southern Brazil. This research will contribute to the qualification of Nursing care and service, considering that this assistance is related to the care provided by the obstetric nurse to parturients and supported by the *Ministério da Saúde* with the *Rede Cegonha* and the *Diretrizes Nacionais de Assistência ao Parto Normal*.^{8,13}

METHOD

This is a qualitative and descriptive study, conducted at the maternity hospital of a university hospital in the south of the country. The research participants were 13 mothers who underwent cesarean section due to labor arrest disorder in this maternity ward. The inclusion criteria were women 18 years old or older, with 37 weeks of gestation or older, with a usual risk pregnancy and live birth.

The participant quantity was determined by data saturation when no new information or theme was added. Saturation defines the sample size and is also a criterion for interrupting data collection.

Data collection was performed through a semi-structured interview in the rooming-in, performed by the main researcher, on the second postoperative day, favoring privacy. The interviews were guided by open questions, addressing labor and cesarean section by an arrest disorder; and they were recorded and transcribed in full, ensuring the complete analysis of the material obtained. The data collection period was from August 1st to September 30th, 2017. The women's anonymity was guaranteed by using the coding from W1 to W13, as "W" meaning of women followed by the ordinal numbering of interviews.

The collected data were analyzed through analysis procedures proposed by Minayo¹⁴. This type of analysis allows making a bundle of relationships based on the identification of a specific theme.¹³ Also in this perspective, thematic analysis is comprised of three phases: pre-analysis, material exploration and treatment of the results obtained and interpretation.¹⁴

The theoretical reference of this study was based on the good practices shown in the *Diretriz de Assistência ao Parto Normal* of the *Ministério da Saúde* (BR).¹² According to the normative, general care during labor should involve respect, bonding, communication and clarification of the procedures performed, a continuous and individualized physical and emotional support, an assessment of fetal well-being, freedom of movement and methods for pain relief. Based on these good practices, this study analyzed the assistance described by the interviewees.¹³

This research respected all the ethical aspects of Resolution 466, December 12, 2012, of the *Conselho Nacional de Saúde*. The *Comitê de Ética e Pesquisa com Seres Humanos* approved it under opinion number 2.051.631.

RESULTS AND DISCUSSION

From the data analysis of this study, three categories emerged.

FRAGMENTED CARE DURING LABOR

The professionals who assisted women during labor were obstetric nurses, Nursing residents, and Nursing technicians. As it is a teaching hospital, undergraduate medical students were also there. Women reported to have fragmented support and in some cases, not performed by the same professional.

There was someone all the time, but they have different shifts, but all the time there was someone present. There was a nurse and medical students (W3).

There were people on duty who follow-up my labor, they helped me in everything, they did not stay exclusively with me, but they gave me a lot of support, it was the Nursing staff (W9).

The nurses were present all the time; in and out (W10).

According to data from this study, the obstetric nurse did not give assistance to all women. Those who received assistance from this professional was in specific moments, that is, the support in labor was not continuous.

In the literature, one of the reasons for the absence of the nurse with the parturients is the administrative and managerial demands that often limit quality care and assistance, with reception in a few moments with the patient even in obstetric centers.¹⁵ However, welcoming the parturient is extremely important for the performance of a respectful birth with listening and dialogue of the professionals involved with the parturient women.¹⁶

Good relationships between the professionals and the women are fundamental to alleviate pain and fear of the unknown. Parturients who did not receive continuous care during their labor experienced loneliness, fear, and sadness at the time, which disqualifies their attention.¹⁷

Some women reported that care during labor was not performed continuously by a professional, but it was only focused on performing examinations and procedures.

There was no one all the time with me, only my husband, but they were always doing the tests, the cardiocography, listening to the baby's heart (W7).

There was no one with me, only to hear the baby's heart and do the touch exam (W7).

The literature found that in the perception of postpartum women about assistance in labor and delivery, the lack of a professional in the same environment meant the abandonment and fear of going through the contractions and pain without guidance and support.¹⁸

Procedures and the use of oxytocin replace the effective presence of professionals with women in labor. These interventions can accelerate childbirth, reducing the length of stay of women in the obstetric center and their bond with professionals.¹⁷ The loneliness and fear experienced by the

parturients can lead to perineal lacerations, as they spend all their labor tense, feeling despair in the expulsive period and in the absence of professionals who encourage them to move during labor. They feel limited to the bed.¹⁷

Although as identified in the data above the maternity of this study has trained professionals to perform humanized care, centered on women and their needs, in some cases, they are not together with the parturients. Thus, women who were only with their partner identify only examinations and procedures focused on the fetus and progress of labor as care, which does not configure a model of comprehensive care.

GOOD PRACTICES IN CARING FOR PARTURIENTS

In 1996, the WHO published the guide to normal childbirth care, which contains good evidence-based labor and birth care practices. These practices have been advocated by *Rede Cegonha* since 2011, highlighting empathic support by providers during labor and delivery, non-invasive and non-pharmacological pain relief methods such as massage and relaxation and freedom techniques of position and movement during labor, stimulating non-supine positions during labor.^{11,18}

With the *Rede Cegonha* implementation, the "*Parto Humanizado*" strategy had the main objective of reducing unnecessary cesarean section rates, qualifying care for normal delivery respectfully and rescuing women's autonomy at the time of delivery with information and education in health.⁸ The presence of the obstetric nurse is essential for the practice of these actions.⁸

The Nursing care mentioned in this study involved physical and emotional support. In the moments that the obstetric nurse was present, the women reported elements characterizing the empathy of the professional, such as words of affirmation, affective gestures, and stimuli to non-pharmacological methods for pain relief.

The nurse and the Nursing resident gave me tips, put hot gloves on my back, they massaged, helped me, they were sweet to me, they talked, put me on the ball, massaged well (W1).

She [nurse] did massage, put me on four supports on the bed, held my hand, told me to take a deep breath, it was very good (W8).

The cutest thing I think I got here was a nurse who when I couldn't take it anymore and wanted to give up, she hugged me and said that I was going to make it, that

I had the strength, that it would be all right and that calmed me a lot (W11).

According to the *Nascer* research in Brazil, only 28% of the usual-risk pregnant women had access to non-pharmacological methods for pain relief during labor and 46% of the same group of women had free movement.¹⁹ Not being "stuck" in bed and free to walk and move as they prefer can shorten the time of labor and interventions.²⁰

Methods such as moving, soaking or sprinkling, and massage are not always effective in relieving pain, but they reduce the parturient's stress and anxiety levels and promote her satisfaction.¹¹ Active professionals in encouraging these methods contribute to a woman's best satisfaction in her parturition process.¹⁸

The obstetric nurse did not provide continuous assistance to the women in this study but used the good practices recommended by the *Rede Cegonha* and WHO. The data showed that the mothers reported satisfaction regarding the assistance of these professionals.

THE PREFERENCE OF THE TYPE OF DELIVERY AND THE REFERRAL FOR CESAREAN SECTION

Most of the interviewed mothers expressed the desire for normal delivery during pregnancy.

I thought about having a normal delivery because of recovery and being the best for the baby (W1).

I would like to have a normal delivery. From the beginning, I did birth insurance thinking about it. I participated in the group of pregnant women at the hospital because I knew nothing, absolutely nothing, and there I gained a little experience about normal humanized delivery and I got interested (W4).

According to data from the research called "*Nascer no Brasil*", 66% of the mothers expressed the desire for normal delivery, but only 42% of them had it; 27% reported preference for cesarean section and 6% did not show a definite preference.²¹ The chances of cesarean section in parturients who want this type of delivery during pregnancy triple in SUS. Having a previous cesarean section increases by 11 times the chances of having the same procedure.²²

Women who desired the cesarean section reported negative experiences than previous labor to justify their preference.

I thought about having a cesarean section, because, in the first child, I spent a lot of time in labor and in the end I had no dilation and they had to take me to emergency cesarean section, because he was already with few beats, it was already short of fluid too (W5).

I wanted the cesarean section because in the delivery of my first daughter I induced her and it was very difficult, I suffered a lot and I ended up in caesarean section, so I already thought about cesarean section again (W8).

Regardless of the final type of delivery, pain during labor is considered stronger than in the puerperium. The pain often associated with long periods of labor is considered distressing, punishing and frightening by women and may influence the choice for cesarean section in future pregnancies.²³

Advantages of normal delivery over cesarean section include the first moment with the child right after birth and breastfeeding in the first hour of life.²⁴ Faster recovery and return to daily activities, less chance of complications after the procedure, immediate skin-to-skin contact of the mother with the newborn, and better neonatal outcomes are also factors in the choice and desire for normal delivery.²⁵

To have the child naturally, it is not enough just the woman's desire for normal delivery. The experiences of women in previous deliveries may determine the choice of delivery in the next pregnancies, and pain and time of labor are significant aspects in the lives of women who were referred for intrapartum cesarean section and may determine this choice.

The common discourse of the women in this study was that they had no dilation and that although the procedures for the evolution of labor were performed, they remained with the same dilation for several hours. Regarding the indication for cesarean section, there were times when obstetricians shared the decision with the parturient and others when there was no shared dialogue with the woman to expose her wishes and possible doubts.

I spent five hours with just seven "fingers". It didn't pass, so they asked me if I wanted a c-section or if I wanted them to break the water to see if it evolved. Then they punctured the water bag, which I preferred, but it didn't evolve anymore (W1).

That's when, in this case, they increased the oxytocin, I was 8 cm and the doctor said: 'she is not dilating'. Then they went outside and talked. Then he said: "Your delivery will have to be cesarean because you are not dilating, and we have tried everything, we have nothing else to do. And

they had already broken the water bag and everything, so I went to cesarean section (W2).

The women in this study described their labor as a process that eventually stopped working and it did not work even after external interventions. This may corroborate other studies that state that delivery in the hospital environment is not treated as a physiological process, but as something that can go wrong and needs interventions and medications.⁷ In maternities, women often act passively, attributing to the professional the active role of deciding and conducting their labor. They assume that some complication will happen and the obstetrician will need to intervene.¹⁸ For women to be sure of their labor and to know their body, guidance on the parturition process must be present throughout the pregnancy-puerperal cycle.¹⁸

The care model that does not allow the parturient and her partner to participate in the decisions and procedures regarding her singular labor process does not stimulate the autonomy of women over their bodies and their time of labor, justifying the high number of obstetric and surgical interventions of cesarean sections in Brazilian maternity hospitals.^{17,19} In the current Obstetrics, besides giving information about the process they are going through, professionals must change their clinical performance beyond routines and procedures, stimulate the active participation of women and their caregivers and provide ongoing physical and emotional support for women to be protagonists of their labor.¹⁷

At the final moment of labor in the women of this study, non-evolution of dilation was considered a determining factor for cesarean section indication. The decision for cesarean section is not always shared with the woman and her partner.

When asked about their feelings at the time they were referred for cesarean section, the women's answers were diverse, but feelings of relief predominated because they knew they would have no further contractions and have to wait for the birth of their child.

With that pain, I felt better knowing I was going to the caesarean section after having been in pain all day (W10).

I was very happy to go to cesarean section, because there is a time when you cannot stand the tiredness, the pain, the hunger, even though you planned the normal delivery at that time you want your baby on your lap, no more suffering (W11).

When a practical and quick way to finish the contractions and the painful process of labor is offered, women experience momentary relief. The ease of birth is a positive point associated

with cesarean section by women.²⁵ Fear of labor pain was present in 82% of interviews conducted by *Nascer* research in Brazil, within the public health network, and influences the acceptance of cesarean section.¹⁹

There have also been reports of fear and distrust that the final route of delivery is different from that desired during pregnancy.

I was afraid because I knew that in a normal delivery, the recovery was faster than cesarean section, when she said it was going to be cesarean I cried, I did not want to, but as she said it was the best choice for the baby, I accepted it. My labor stopped and I couldn't take the pain anymore, I was very weak, I was two days without sleep. But I support it as long as I could (W9).

Look, I won't tell you that I didn't get suspicious. I thought I would be more nervous because my first baby was a normal delivery, but I was very calm (W12).

Fear, distrust, and crying were reported by women at the time of referral for the cesarean section. Even receiving the indication of the obstetrician, negative feelings regarding cesarean section were present.

The fear of cesarean section unlike normal delivery is the complexity of surgery, postoperative difficulty and not having the satisfaction of naturally giving birth to their child.^{5,25}

The different feelings in the referral to the cesarean section in this study corroborated the uniqueness of women, especially in the parturition process. As individuals with different needs and feelings, care and assistance for them should be in accordance with their particularities.

CONCLUSION

At the end of this study, it was possible to know the care provided to women who underwent cesarean section by a labor arrest disorder, from their experiences and perceptions.

Normal delivery was the most desired by pregnant women. Those who desired cesarean section reported pain and time of labor in previous pregnancies that also did not progress to normal delivery as negative and determining aspects of their desire for cesarean section in the next pregnancy.

The professionals mentioned by the women were obstetric nurses, Nursing technicians, doctors, Nursing residents and also undergraduate medical students. The assistance in this study was fragmented, focused on monitoring labor, and not always performed by the same professional. The speeches highlighted the role of the obstetric nurse. Humanized care, good practices, empathy, emotional and physical support summed up the care

of these professionals, but they also did not practice continuous support to the parturients. The results showed the satisfaction of the mothers for the contact they had with obstetric nurses during their labor. In the absence of these professionals, women identified routine technical procedures as a type of care.

When their labor stopped to evolve, women identified it as a failure of their bodies to develop the natural delivery of their children and then underwent a cesarean section. The decision on the type of delivery has not always considered the opinion and desire of the woman and her partner, even if it is a relative indication for cesarean section. In the cases studied, there was failure or arrest disorder of the women's labor, but there was also failure to assist them, as the continuous and quality support and encouragement to participate in decisions made regarding their bodies were not practiced.

The teaching and qualification of professionals involved in care should be performed routinely to raise awareness of aspects beyond the physical aspects of the labor in each woman. As evidenced in this research, women in labor are also individuals with singularities in their parturition process that must be respected.

The study contributed to the qualification of assistance to women in labor, showing the methods identified by the parturients as positive and that helped them when they needed them.

The limitations of this study were the women interviewed soon after the cesarean section recovery and had not yet reflected more deeply on the process experienced; and the scarcity of qualitative and up-to-date studies on the care of women during labor.

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