

Meanings expressed by the chaperone about their inclusion during the childbirth assisted by nurse midwives*

Significados expressos por acompanhante sobre a sua inclusão no parto e nascimento assistido por enfermeiras obstétricas

Significados expresados por acompañantes sobre su inclusión en el parto y nacimiento asistido por enfermeras obstétricas

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Abstract: Objectives: to describe the characteristics of the parturient's chaperone at the obstetric center at a maternity hospital of the municipality of Rio de Janeiro and comprehend the meaning attributed by them to their presence during the childbirth assisted by nurse midwives. **Method:** qualitative approach and descriptive character. Semi-structured interviews were carried out with 31 chaperones, after experiencing the childbirth assisted by a nurse midwife. The collected data was systematically organized and subjected to content analysis. **Results:** the chaperone's involvement in the childbirth is guaranteed to the parturients; their choice involved the interests of

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* Extracted from the Research Report titled "The Involvement of the chaperone in childbirth by a nurse midwife: a proposal of attention for the (in)direct client", Postgraduate Program in Health and Technology of the Hospital Space - Professional Master's Degree, Federal University of the State of Rio de Janeiro, 2018.

family members, especially their partners, in sharing this moment. The provided assistance by nurse midwives is identified as a facilitator for the inclusion of family members, integrating their presence to the provision of care aimed at comfort and pain relief during labor. **Conclusion:** the interaction between nurse midwives and chaperones provided the participants with comfort and security with natural labor, feelings of gratitude and satisfaction.

Descritores: Parto normal; Parto humanizado; Salas de parto; Relações profissional-família; Enfermeira obstétrica

Resumo: Objetivos: descrever as características do acompanhante da parturiente no centro obstétrico de uma maternidade do município do Rio de Janeiro e compreender o significado atribuído por eles à sua presença no parto e nascimento assistido por enfermeiras obstétricas. **Método:** abordagem qualitativa e caráter descritivo. Realizaram-se entrevistas semiestruturadas com 31 acompanhantes, após vivenciarem parto assistido por enfermeira obstétrica. Os dados coletados foram organizados sistematicamente e submetidos à análise de conteúdo. **Resultados:** a participação do acompanhante no parto está garantida às parturientes; sua escolha envolve o interesse dos familiares, principalmente dos parceiros, em compartilhar esse momento. A assistência prestada por enfermeiras obstétricas é identificada como facilitadora para inclusão dos familiares, incorporando sua presença à realização de cuidados voltados para conforto e alívio da dor no trabalho de parto. **Conclusão:** a interação entre enfermeiras obstétricas e acompanhantes proporcionou aos participantes conforto e segurança com o parto normal, sentimentos de gratidão e satisfação.

Descriptors: Natural childbirth; Humanizing delivery; Delivery rooms; Professional-family relations; Nurse midwives

Resumen: Objetivos: describir las características del acompañante de la parturienta en el centro obstétrico de una maternidad de la ciudad de Río de Janeiro y comprender el significado que le atribuye a su presencia en el parto y nacimiento asistido por enfermeras obstétricas. **Método:** enfoque cualitativo y carácter descriptivo. Se realizaron entrevistas semiestructuradas a 31 acompañantes, luego de que pasaran por la experiencia de un parto asistido por una enfermera obstétrica. Los datos recopilados se organizaron sistemáticamente y se sometieron a un análisis de contenido. **Resultados:** la participación del acompañante en el parto es un derecho de las parturientas; optar por ella involucra el interés de los miembros de la familia, especialmente de la pareja, en compartir este momento. La asistencia brindada por enfermeras obstétricas se identifica como facilitadora para la inclusión de los familiares, al incorporar su presencia en los cuidados orientados a la comodidad y alivio del dolor durante el parto. **Conclusión:** la interacción entre enfermeras obstétricas y acompañantes brindó a los participantes comodidad y seguridad en un parto normal, además de sentimientos de gratitud y satisfacción.

Descriptorios: Parto normal; Parto humanizado; Salas de parto; Relaciones profesional-familia; Enfermeras obstetricas

Introduction

Pregnancy, labor and birth are unique moments, full of meaning to the woman and everyone involved in it (mother, father and family). They evoke emotions, redefine feelings, have the potential to stimulate the formation of bonds and cause personal transformations.¹The birth of a new life also encourages family structuring and organization, the adapting of new conditions and roles among family members, being influenced by the sociocultural context in which it occurs.²⁻³

The institutionalization of childbirth, accompanied by technological advances and the improvement of the obstetric methods, imposed a ritual to the act of giving birth – marked by routines and standardization of professional actions – which hinders the individualized assistance, the respect to the uniqueness of the individuals and, mainly, makes it impossible to the woman to participate as the protagonist of her own process of becoming a mother.¹ Thus, the attention to childbirth started to be characterized by unnecessary and iatrogenic interventions, including the abusive practice of the caesarean section, the regular use of episiotomy and synthetic oxytocin, contributing to the isolation of the pregnant woman from her family members and disfavoring the development of early bonds, privacy and the respect for her autonomy.¹

In other words, the assistance provided to women during childbirth in hospital environments caused the control of the pregnant woman's physiological and behavioral evolution, moved the woman away from the family involvement built in feminine and domestic spaces, where they were linked to strong social bonds.⁴ In the maternity hospitals, the understanding that women are not capable to endure labor pains and to command their own bodies to give birth, devoid of professional aid to win over the difficulties imposed by an imperfect body, favored the change of the protagonist role in the parturitive process to a more passive posture, once the hospital routines were established to meet the professional needs and demands, disregarding those of the parturients.⁴⁻⁵

The recognition that this model of childbirth care contributes to the neglect of some practices that made birth possible to women and their family beyond the biological meaning indicated the need for change in labor care, of the rescue of natural care practices proposed by the Humanization of Childbirth movement.³ This humanized action involves a set of knowledges, practices and attitudes that aims to promote a healthy childbirth, ensuring that the health team performs procedures proved to be beneficial to mother-child, thus, avoiding unnecessary interventions and preserving the women's privacy, autonomy and rights. In this

perspective, one of the recommendations consists in the return of family members to the childbirth scene, especially the father.^{1,3-4}

It is the inclusion of a person of the woman's choice, someone trustworthy that is part of her social network, regardless of the degree of kinship, that allows her to feel emotionally and physically supported, with the purpose to minimize the fears and insecurities of the parturient for only being in the company of unknown professionals in the hospital environment.^{4,6} This choice is ensured during labor, birth and immediate puerperium, according to Federal Law No. 11,108, of April 7, 2015.⁷

The ongoing support provided by a family member chosen by the parturient soothes the feelings of loneliness and anxiety, grants safety and well-being, minimizes the levels of stress caused by the woman's vulnerability and by other factors such as discomfort during labor, fear of what is to come, of the unfamiliar environment and the contact with unknown people.³ The involvement of the family member is effective in helping the woman to endure pain; contributes to her satisfaction, to the development of affective bonds, higher Apgar scores, shorter labor time; and reduces the need for instrumental delivery, factors that positively impact the perinatal indicators, the period of hospitalization and hospital costs.⁸⁻¹³

In view of the benefits generated by the presence of the chaperone in the delivery process, it is necessary to expand the discussions on the inclusion of these individuals in institutionalized care spaces, to know the process of choosing the family member by the woman, the expectations and insecurities of the chaperone and their reception at the maternity hospital; thus, to ensure both the needs of the parturient and the possible assistance demands of the chaperone. The pregnancy should not be understood as only a binomial mother and child, therefore it is fundamental to guarantee the participation of a family member chosen by the woman to take part in the process, once the care initiated by the health team will continue in the domestic routine, with the support of this member motivated to become an active participant.¹⁴

These discussions are relevant and possible because it is characteristic of the nurse midwife to embody specific skills necessary to the implementation of the humanized model and aimed at respecting the physiology of childbirth, since they act like the mediator between pregnant women, chaperones, other professionals and the hospital institution, associating their sensitive view to the identification of the necessities of care presented.^{1,15} In the context of labor, the support of the nurses is a facilitator to the inclusion of the family member in the execution of the nursing care. Their skills encourage the active participation of the chaperone in the care given to the woman, leading him to rethink the meaning of birth; as well as fitting into the environment, an important thing in moments of fragility for them and the parturient.^{6,16}

The care of nurse midwives in the childbirth care allows the construction of a therapeutic relationship based on the establishment of dialogue, bond and trust, in order to establish a favorable environment for the childbirth, with less interventions and better outcomes, based on their attitudinal, communicative and affective skills.¹

Given these considerations, the question is: what is the meaning of being a chaperone during childbirth? The reflection on actions aimed at the inclusion of the chaperone in the childbirth scene, recognizing their reality and the reasons that motivate their presence, supports the aspects of the humanization in childbirth care and promotes a model of care with greater participation of the parturient and her family as protagonists of the process.

Based on the necessities to project the view of obstetric care to the parturient's chaperones, in order to recognize their needs and experiences, the objective of this study is to: describe the characteristics of the parturient's chaperone in the obstetric center of a maternity hospital in the municipality of Rio de Janeiro and understand the meaning attributed by them to their presence at the childbirth assisted by a nurse midwife.

Method

A study of qualitative approach and descriptive character, since it seeks to comprehend the intensity of the phenomena and its sociocultural dimensions, as the individuals need to be understood in their environment, in their history and in their circumstances.¹⁷ The setting was the obstetric center in a public maternity hospital of the municipality of Rio de Janeiro, that offers assistance to pregnant women coming from the Unified Health System (Sistema Único de Saúde) and allows to every parturients the presence of a chaperone of the woman's free choice.

This study counted on the participation of 31 chaperones that were involved in the experience of childbirth, based on the following inclusion criteria: being the chaperone of women classified as regular risk that had a natural childbirth assisted by nurse midwives; have remained during every clinical periods of childbirth and; age over 18 years old. The capture of new components was delimited by the saturation criterion, as far as the reports provided by new participants started to add little information to the material already collected, without a significant contribution to the refinement of the theoretical reflection founded on the collected data.¹⁸

The selection of the participants stemmed from visits to the obstetric center with the intention to observe and verify the presence of the chaperone during the labor and birth process. The invitation to participate on the study was proposed still on the obstetric center, right after birth, in the search to sensitize them to share their experiences regarding the participation in childbirth.

The interviews were recorded in digital devices, with the participant's authorization. They lasted an average of 15 minutes and took place in reserved spaces, according to the unit's availability, in the period of September to November 2017. A tool composed of two parts was used: the first had questions for the characterization of the demographic data of the chaperones; the second, questions related to the experience as a chaperone in childbirth.

The statements were submitted to content analysis, following the stages of pre-analysis, material exploration and thematic analysis. Afterward, the results were treated based on inference and interpretation.¹⁹

The information was coded, segmented and enumerated according to its quantitative and qualitative assessment,¹⁹ in an attempt to understand not only the meaning of the statements, but to go deeper into the messages and start to interpret them in a way that the research question and its objectives were analyzed in the light of scientific productions related to the theme. These procedures made it possible to systematically organize the information, which were coded, segmented and enumerated, considering the presence or absence of given characteristic in convergent statements, and the capture and structuring of central ideas in tables for better visualization of the selected content; observe the representation and homogeneity; understand the meaning of the statements; go deeper into the messages and seek conclusions, according to the objectives, allowing, at last, the construction of the analysis category.¹⁹

The study was submitted for evaluation by the Research Ethics Committee (Comitê de Ética em Pesquisa) of the Federal University of the State of Rio de Janeiro, having been approved under the Report No. 2,265,938, on September 10, 2017. All of the requirements of the Resolution No. 466/2012 of the National Health Council (Conselho Nacional de Saúde) were met. All of the participants signed the Free and Informed Consent Form and the interviews were identified by Arabic numerals, obeying the chronological order of data collection, in order to guarantee the anonymity of the participants.

Results

The demographic characteristics of the participants are shown in Table 1. The composition of the sample involved chaperones around 21 to 68 years of age, with an average of 31 years old and 45% in a range of 18 to 30 years old. It was observed that 55% were male (55%),

motivated by the desire to be with their partner during their child's birth. Most of the marital relationships were declared to be stable union.

The female participants corresponded in 23% to the mothers of the pregnant women; sisters and other affective ties such as friends, aunts, mothers-in-law and sisters-in-law represented 10%, illustrating women's autonomy in choosing their chaperone. When asked about their participation in the prenatal care, 69% reported having accompanied the pregnant women during the consultations.

As for the level of education, 45% of the interviewed attended high school, followed by 29% with complete elementary school. Regarding the profession aspects and the insertion in the job market, 65% performed formal activities, in different types of occupation/profession.

Table1-Demographic data of the chaperones, Rio de Janeiro, RJ, Brazil, 2017 (n=31).

Variable	n	%
Age		
18 to 30 years old	14	45.0
30 to 39 years old	3	10.0
40 to 49 years old	8	26.0
> 50 years old	6	19.0
Sex		
Male	17	55.0
Female	14	45.0
Family relationship with the pregnant woman		
Father of the baby	17	55.0
Mother of the pregnant woman	7	23.0
Others	7	23.0
Close relationship with the pregnant woman		
Stable union	12	39.0
Marriage	5	16.0
Member of the family	11	35.0
Friendship	3	10.0
Involvement in the prenatal care		
Yes	19	61.0
No	12	39.0
Level of education		
Incomplete elementary school	6	19.0

Complete elementary school	9	29.0
Complete high school	14	45.0
Complete higher education	2	6.0
Employment bond		
Formal employment	20	65.0
Informal employment	8	26.0
Unemployed	2	6.0
Retired	1	3.0
Professions		
Cook	3	10.0
Cashier	3	10.0
Self-employed	4	13.0
Production assistant	1	3.0
Stay-at-home	4	13.0
Construction worker	2	6.0
Driver	1	3.0
Caregiver (elderly/children)	3	10.0
Nursing assistant	1	3.0
Retired	1	3.0
Airport officer	1	3.0
Watchmen	2	6.0
Retailer	5	16.0

The data analysis allowed the development of the category named: **The experience of being the chaperone chosen by the parturient: the meaning of the involvement in childbirth**, which addresses the woman's autonomy in the process of choosing the person of trust who will be present during labor and birth; the structure of the paternal presence in the childbirth scene; the interpretation of the participants in experiencing childbirth. The contributions of the nursing midwifery to the reception of the parturient's chaperone in this scenario are also revealed.

The decision about the presence of the chaperone is made by the parturient and passes through interactions in the family context, which can be shared between the woman and the family members when they realize that, besides helping, they can provide security to the parturient and her baby:

I have been her chaperone since the first one, it's a trust she has in me. [...] So, it's always me, whenever she has a baby, the first thing, person, that

she will think of, without a doubt, will be me. It's because we are sisters, so we're already very close, but also because she already trusts in me, that I won't make her nervous. (E4)

The choice of a chaperone happens still during the pregnancy, leading to the improvement of communication in the family relationship and the inclusion of them in the activities developed during prenatal care – a time of preparation and guidance for this relationship. However, the early choice does not determine a greater connection of the chaperone in the prenatal period, since 39% of the participants could not be present during the consultations. This finding is related to the difficulties imposed by the business hours of the outpatient clinics and with the restrictions of the labor rights that should, at least, ensure the father's attendance to the consultations.

No, I couldn't for the prenatal I couldn't, I'm very busy on the street and such, but I always told her to go, everything just right. [...] when she arrived home, she always talked to me, told me everything they explained to her. (E5)

No, I didn't participate, I have work, I only got involved in this very moment of being here with her today. Only in the room, only in the room. (E11)

For a group of participants, the invitation to be in the delivery room was characterized as the woman's assertion, by her desire to be close, especially of her partner, during an unique event in life. And they accepted, despite feelings of fear, anxiety and insecurity of witnessing childbirth:

She was the one who chose, forced it, even that [...] I'm kind of weak, I don't like to see blood. I get kind of nervous. But it was a great experience. Get it? She chose me. She came to me and said: "I want you with me during labor!" (E1)

Currently, men get involved in everyday issues, adopting a more acting and affective attitude in the care of their children and family.

It was mutual. The last time we didn't stay together. This time we had the opportunity[and] we did. (E3)

She did too, but [...] at first, she was torn between me and her mother. Then, when I stood my ground, I said I wanted to, I wanted to watch, she said that it was fine! I went with her myself. (E8)

Being with the parturient during the whole process of evolution of childbirth forms the imagination of the participants based on ideas and expectations of prenatal experiences, previous experiences, stories told by others, information received about the service at the maternity hospital, through social media, as well as their assessments of the conditions imposed by the current structure of the health system.

It was mine, so I can make her feel safe and she can pass it on to me. Not that much, she was strong, she was pushing hard. (E1)

No, from the beginning I said I was going with her all the way, I don't leave her alone, I want to participate in everything. I said: "No, I'll go, I'll go". Then she even said: "If you don't want to, if you're nervous, and stuff". Because I was, we came in the morning, I couldn't eat, sleep, super nervous. No. I wanna be there, wanna be there, and went. It was great!(E5)

Intensely experiencing childbirth engenders challenges and discoveries in the face of the pain and discomfort caused by labor. If on one hand there are difficulties, on the other there are positive testimonies of the experience, such as the possibility to offer physical support, transmitting peace, security and emotional support during labor; feelings of satisfaction and gratitude for being chosen and witnessing the birth, overcoming limitations through touch, holding the woman's hand and being able to say words of encouragement.

I stood by her side the whole time, grabbing her hand, talking to her, asking her to stay calm. "Push, breathe", these things, to [...] keep her calm and confident. (E1)

I gave her a massage. Yeah, I massaged her so we could comfort her. Always being there with her, walking, there around the bed. And also outside so she could go for a walk. It was all so close, holding her, at the table with her, it was wonderful! Me and her, it was really good!(E9)

In addition, they reported feelings of gratitude, illustrated by the statement that portrays their appreciation of the puerperal woman for the presence of the partner who, in turn, recognizes the strength of his wife:

Being there was even more thrilling, because she said that, if I wasn't there, she wouldn't have made it. But I know that she did it because I know that she's strong. But there, at the time, it was an amazing experience, that, if I have a next one, two, I wanna go again. I wanna see it again. (E1)

She, unintentionally, showed something. She managed to show even more how important I am to her and how much I can still give back! That everything I did is nowhere near this moment, of what she trusted, so I have to give her more. (E10)

Once welcomed at the maternity hospitals, the participants reported the importance of the approach offered by the nurse midwives and showed interest in knowing the physiology of natural childbirth, in contributing to minimize the parturient's complaints, making the labor faster and less painful. Some reports of losses during orientation gave them the impression of helplessness, depreciation of the pain referred by the parturients and the feeling of fragility in the parturient-chaperone relationship.

What about me, what am I gonna do? I can't break in. I tried to talk to the doctors who were inside, I tried, but they said: "She's not even in labor yet". Not even twenty minutes later, she was there already having the baby. She was there in despair and it despaired me. (E4)

[...] I said that she was in a lot of pain but nobody said anything. "You have to wait, the pain is like that, you can't give medicine, you have to wait". I think people would have to help more, guide more! To say: "No, she is

feeling this pain". I don't know [...] give some advice, talk, support her.
(E30)

The chaperones mentioned the constant presence of the nurse midwife during the labor process. However, a small group of chaperones indicated the presence of this professional only close to the expulsion period and the birth of the baby; which suggests that, in these cases, there is less interaction and the establishment of a bond between the chaperone and the nurse responsible for the childbirth assistance, besides the feeling of loneliness and insecurity during the process:

We didn't have that person to support us there, you know? I missed that. If we arrived here at two-thirty in the morning, three in the morning, and labor began, it would be very important to have someone with us. [...] I think the person needs to be there to be able to stay with us, if that person is, then you don't even need that many people in the delivery room. (E9)

No, although everyone was very close, we were feeling insecure, afraid [...] we asked the nurse: "If the baby starts to get born, what do we do?" We stay alone in the room we didn't know what would happen. (E30)

On the other hand, some professional attitudes minimize the feeling of loneliness and anguish when transmitting security in their actions and orientations, positively influencing the positive perception of the participants about the provided assistance, such as the availability to meet requests, the fulfillment of the promised care offer, the commitment to return to the service room in case there is a need to be absent, demonstrating compassion to the referred pain and flexibility to offer enlightening guidance.

I had a nurse that was there. There was always someone worried [...] she was with us, always: "I'm going to deliver a baby now, but as soon as I'm done, I'll come looking for you". Said and done, she went, looked, and there we were in the room to have the baby, and she: "No, I'm going to stay with you until the end!" So, these are the things that, really, there's someone with me, who wants to make it happen with me! (E10)

Pregnant Women and their chaperones had access to different non-pharmacological methods to relief the painful sensation of labor, offered by nurse midwives, emphasizing the breathing techniques used in 87% of the parturients, free ambulation (19%), body massages (42%), pelvic movements (29%), warm baths (29%), among others.

That's when she [nurse midwife] brought this stool and she started pushing on the stool, with me holding it. (E15)

I gave her a massage, I did a lot [...] I taught breathing exercises, squatting! Back massages, in between contractions I did back massages, I put her in the water. (E22)

The choice to use these resources is conditioned to the preferences of the woman in labor, based on the decision process shared between the parturient and the professional doing the childbirth assistance. The option to perform one of these methods, besides providing benefits to the parturient, allows the active participation of the chaperone in the development of the exercises and the use of the instruments, as the testimony points out:

I thought the water would break and in 15 minutes the baby was here, it wasn't something that would take too long. [...] you see all the suffering on the part of the mother and the support that the nursing team gave it was really cool. X [nurse midwife] herself helped, helped a lot, with a lot of patience, putting on music to help relax, she even sprayed an essence to relax the environment, and gave massage to really relax, to take away that tension. (E26)

The interaction between parturient, chaperone and nurse midwife reveal adherence to the humanized practices focused on the physiological aspects of the female body, valuing natural and humanized childbirth and the adoption of non-invasive methods to decrease the painful sensation, through the involvement of the chaperones. This way, the respect of these professionals is shaped to the dignity and autonomy of women, as well as the encouragement to

rescue the active role of the parturient, represented in the choice of how to give birth, who will be present and what actions may bring greater relief and comfort to the woman.

Discussion

The parturient-partner relationship was the most prevailing bond in the studied sample, revealing the same trend as other studies.^{4,16,20} The choice of the chaperone by the woman has an individual character, based on her cultural and social conceptions and assessments, feelings and depictions regarding the pregnancy, the experience she hopes to have; to, thus, identify the type of support she wants and which person in her social network is most applicable to that moment.

The father's participation, in the time of the delivery, combines with the new condition of paternity, marks the gender transformations and provides important reflections on the role of men. It is worth to emphasize that the male presence in the childbirth scenario has been increasing: among the female choices, motivated by the search for security, partnership, sharing of responsibilities; and among men, by the desire to offer support, protection, strength, confidence and courage to the woman.^{4,16,20,23} Parents also have expectations and curiosities about their role during childbirth, showing a willingness to be present, participate and understand the process.^{4,24} This participation contributes to the formation of bond, the strengthening of family ties and the realization of participatory and active fatherhood.

To a lesser extent, the participation of mothers, aunts, sisters and friends supports the plurality of bonds in the sample and portrays the exercise of the right to choose. The characteristics of the choice of chaperones by the puerperal women participating in this study were constituted as close people, with whom they had affective bonds, in whom they could place their trust, who transmitted safety, support and tranquility, which reinforces the links and provides benefits to everyone involved: woman, baby, chaperone and health professionals.^{16,20}

Hospitalization represents the woman's departure from her family environment to share the space with other women and unknown professionals. This change can interfere with the physiological responses in the first two clinical periods of childbirth (dilation and expulsion). For this reason, the presence of someone of trust is an alternative for establishing communication, bonding and psychological safety.²⁵

This study's sample was composed, primarily, by participants who completed high school and were engaged in paid activities, characteristics that reflect the access of this population to education, although low income communities are located around the observed institution. The group's education leads to reflections on the access and importance of objective and clear guidance from professionals and the relationships established with parturients and their chaperones since prenatal care.

In this study, the participation of the same family member is observed both in childbirth as in prenatal consultations. It is during consultations that the professional has more time to exchange information and the pregnant woman and her family's necessary individual delimitation, having in mind the preparation and in order to clarify beliefs and myths that might generate anguish and anxiety during labor.¹⁴ Therefore, the activities developed since prenatal care need to be directed towards promoting dialogue between the pregnant woman, her family and the health professionals, providing information about the physiology of labor and the pain as part of this process, as well as presenting non-pharmacological methods for pain relief that can be performed by the chaperones.¹⁴

The relationship between the chaperone's education, knowledge of law, the access to information and the questioning attitude is fundamental to the protection of the woman in the childbirth scene. Data from the "Nascer no Brasil" (Being Born in Brazil) survey show that brown/black women and users of the Unified Health System; low-income women; and with a lower level of education as the most vulnerable to remain unaccompanied during childbirth.²⁶

According to a study carried out in the South of the country, which investigated the satisfaction level of the chaperones regarding the service and the information received during childbirth care, users, the participants with higher education questioned more the professional attitudes, the hospital routines and were more informed about their rights and laws.¹³

During parturition, intense physiological, subjective and psychological changes happen in the woman, interfering with her desires and lowering her ability to react to professional actions. As a particular even, childbirth becomes a visceral experience and, in this scenario, the protection of the chaperone strengthens the woman so that she can better support the pain; it minimizes stress; allows her to express her emotions by shouting, moaning or crying. This collective reception contributes to the transcendence of the pain of uterine contractions, which gradually evolve in intensity and discomfort.

That way, the chaperone's permanence involves, primarily, emotional support to the parturient, and collaborates with the health team, whose available time and conditions are insufficient for an exclusive service to each woman. According to the chaperones, the main activities developed by them were being present, offering support and words of encouragement, touch, holding hands and giving massages. Moreover, studies list other activities such as assisting in walking, serving as support for the enactment of upright positions, transmitting calm, given the woman's needs to share her fears and yearnings with someone who maintains a constant presence throughout the process.^{10, 14, 25}

The actions performed by the chaperones promote results as important during childbirth as the obstetric care given by the professionals themselves. The nurse midwives are responsible for identifying the needs of the chaperones, the parturient and her baby; recognizing the critical moments when their interventions are necessary to ensure the health and well-being of everyone in the delivery process.

Upon being welcomed by the institution and its professionals, the chaperone is encouraged to develop actions of physical comfort, besides positioning themselves as an intermediary in the care between the parturient and the nurses, once they take on the role of spokesperson or security of the woman. This harmonious posture between the involved suggest a conquest of the assistance space, with tranquility and security so the childbirth can be experienced, while demonstrating the bond and responsibility of nurse midwives.

The role of the companion and the professional tends to complement each other, providing a satisfactory experience for women in their parturition process and better perinatal results.²⁵ The professional needs to be careful not to delegate pain relief care as a function of the chaperone, but as an opportunity to strengthen bonds and generate shared comfort.

During the data analysis, it was possible to infer that the participants understood the importance of their presence in the delivery room, through feelings of gratitude to the invitation made by the pregnant woman, the desire to be present and contribute positively to the well-being of the parturient and the baby, the feeling of privilege for representing a safe source of physical contact and emotional support, of the emotions described in detail in the statements. The chaperone's active participation during the parturition process makes it so they assume the role of provider of support to the parturient, distancing themselves from being a mere spectator or supervisor of the care provided to the woman and her baby.^{3,15,16} Being included and recognized as a collaborator in the actions given to the parturient configures them as citizens in the space destined for birth, thus, they feel attended to their difficulties and expectations, identified as an important part of the process by the professionals and the parturient herself.

The chaperones have expectations related to the childbirth experience, influenced by social, cultural and historical issues, bringing with them their own representations and meanings regarding their participation, which will influence the parturient's behavior.^{4,25} Another source of emotion for the chaperone is the birth, as it receives, at that moment, new assignments and

responsibilities in the face of pain and discomfort caused by labor – often instinctively developed when there is no prior preparation. This requires greater attention and support from the team to raise his will and minimize his fears of helping and being part of the process.⁴

In that way, the professional approach should promote a welcoming environment, sensitive to the family moment, collaborating with essential information and widening the chaperone's desire to integrate and be a protagonist in the process, actively as a support provider for the parturient.⁴ However, to be an active part in the delivery process, the family needs knowledge and initiative, as well as being welcomed by the nurse midwives. Therefore, the team must be able to promote mutual trust and have attitudinal skills of solidarity and empathy in the institutions.

The earlier the guidelines for monitoring the childbirth process, the better for the chaperones. These should be started during prenatal care and remembered upon arrival at the obstetric center. Participation in educational events such as groups of pregnant women, training, preliminary awareness-raising with couples and family members during prenatal care, visits to the maternity hospital to promote orientations (reinforced when arriving at the maternity hospital) favors the participation and adoption of active postures by women and their chaperones in the birth scene.

However, the participation in educational activities was not a reality identified in the studied sample, justified by difficulties in accessing the established times for the activities, just as it occurs in prenatal consultations. It is noteworthy that the law promoting the right of choice of women over their chaperone guarantees their presence only during labor, birth and puerperium, without considering the intimate relationship between the prenatal care and childbirth and without involving the guarantee of participation of the family member during prenatal care.¹³⁻¹⁴

The promising path to minimize the effects of the absence of prepare for the chaperones consists on empathetic support, as well as giving orientations and explanations by the part of

the health professionals to establish effective communication, build a therapeutic relationship and a resolute and less interventionist conduction of childbirth.

The assistance offered by the nurse midwife to the study participants provided interaction and support so that they were included in the childbirth care space. These professionals reconciled their orientations with the knowledge of parturients and chaperones, building a linear relationship between them. This way, their performance became of a facilitator, fulfilling the part as a mediator between the different participants, promoting well-being to the individuals through the care aimed to the individuality, complexity and making the chaperone and the parturient the protagonists of the childbirth process.

The nurse midwives also facilitate the development of the chaperones in promoting the parturient's comfort and pain relief, based on joined and guided action of non-pharmacological methods to relief painful sensations on childbirth.^{4,25} In this way, the attitudes shared with the participants in the development of exercises contributed directly to the interaction of everyone involved in the scenario, especially to sooth the situations that could seem, to the parturient and her chaperone, as negative in the parturition process. Besides, they collaborate to take away fear, facilitate the physiological evolution and minimize the negative judgement of the childbirth experience.

The results do not exhaust the search for new evidence related to the presence of the chaperone of the woman's free choice in the labor process, once the study was limited to the reality of a single institution in the municipality of Rio de Janeiro. Thus, it requires investigations in order to unveil new realities and possibilities of offering attention directed to the social and epidemiological characteristics of each territory.

Conclusion

The presence of the chaperone is a practice embodied in the institution observed in this study, in harmony with the movement to humanize the birth process, which provides positives aspects for both mother, child and chaperone as for health professionals and perinatal indicators. Ensuring the parturient's autonomy in the decision of who will chaperone her in the time of delivery means providing the strengthening of bonds in the mother, chaperone and baby triad; giving a concrete form to more democratic institutional spaces; and combine the desire of the family members to collaborate, helping them to overcome their fears, insecurities and concerns about how it will be and what reactions they will have during the whole delivery process.

Male participation was highlighted among the studied group, in which the restructuring in the family construction was emphasized; the inversion of roles due to the achievements of women in the professional life and the adoption of new attributions to the male universe; the greater participation of men in family relationships, contributing in domestic and child care. In this study, the interests of the babies' parents in the information transmitted in the prenatal period was highlighted, even though they were not able to be present in the consultations; and the desire to be besides the parturient offering support, care and protection, combined with a new role in the childbirth scenario.

The chaperones expressed, mainly, the feeling of gratitude for having been chosen by the woman and being able to experience the birth; and recognized the female strength and power through the act of giving birth. Being the chaperone means to satisfy the desire of being close to the pregnant woman; to care for the integrity and security of the woman and the baby, through touch, words of comfort, assistance in pain relief actions; negotiate the assistance, based on the offer of welcoming and attentive care by the nursing midwifery team; and recognize the guidance received in interactions with professionals in the maternity hospital. These attitudes are responsible for reframing their participation in childbirth.

It can be said that the chaperone's (re)signified their values and beliefs, based on the skills and abilities demonstrated by the nurse midwife, for the appraisal of their practical performance and availability to integrate them with non-invasive care to the pain relief of childbirth, allowing the emergence of emotions and feelings. Elements that contribute to the teaching of nursing midwifery, as they incorporate new meanings to the performance of this professional.

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Chief Scientific Editor: Cristiane Cardoso de Paula

Scientific Editor: Tania Solange Bosi de Souza Magnago

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How to cite this article

Quaresma MLJ, Viana AD, Figueiredo NMA, Machado WCA, Tonini T. Meanings expressed by the chaperone about their inclusion during the childbirth assisted by nurse midwives. Rev. Enferm. UFSM. 2020 [Accessed on: Years Month Day]; vol.10 e83: 1-25. DOI: <https://doi.org/10.5902/2179769240829>