INSTITUTO POLITÉCNICO DE SANTARÉM

ESCOLA SUPERIOR DE SAÚDE DE SANTARÉM

O Empoderamento Social

do Enfermeiro Especialista em Enfermagem de Saúde Materna e Obstetrícia

Relatório de Estágio apresentado para a obtenção

do

Grau de Mestre em Enfermagem de Saúde Materna e Obstetrícia.

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“... pode acontecer que pensar ponha em causa,
ou seja,
interrogue o sentido do socializado,
do que reproduzimos porque “sim”,
porque “sempre assim foi”,
porque “toda a gente faz assim”
ou pelo que julgamos que esperam de nós.
Pode ainda acontecer que sejamos congruentes com o pensar
e que,
por via de termos pensado,
modifiquemos (devagarinho, ...)
os hábitos instalados.”

Nunes, 2006

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Sem eles e a sua compreensão não teria conseguido.

A todos, o meu mais sincero Obrigado!

ABREVIATURAS, ACRÓNIMOS E SIGLAS

BP - Bloco de partos

CCEE - Competências Comuns do Enfermeiro Especialista

CEEEESMOG - Competências Específicas do Enfermeiro Especialista em Enfermagem em Saúde Materna e Obstétrica

CMESMO - Curso de Mestrado em Enfermagem em Saúde Materna e Obstétrica

CNSMI - Comissão Nacional de Saúde Materna e Infantil

DL - Decreto Lei

EBSCO - Base de Dados para Pesquisa Científica Online

ESMOG - Enfermagem de Saúde Materna, Obstétrica e Ginecologia

EEESMOG - Enfermeiro Especialista em Enfermagem de Saúde Materna, Obstetrícia e Ginecologia

ESSS - Escola Superior de Saúde de Santarém

EUA - Estados Unidos da América

HAP – Hospital de Apoio Perinatal

HAPD - Hospital de Apoio Perinatal Diferenciado

INE - Instituto Nacional de Estatística

MCEESMO - Mesa do Colégio da Especialidade de Enfermagem de Saúde Materna e Obstétrica

N.º - Número

NE - Nível de Evidência

OE – Ordem dos Enfermeiros

OMS – Organização Mundial de Saúde

p. - Página

pp. - páginas

PNS - Plano Nacional de Saúde

PNSMI - Plano Nacional de Saúde Materna e Infantil

REPE - Regulamento do Exercício Profissional dos Enfermeiros

RN - Recém nascido

RRMI - Rede de Referenciação Materno Infantil

RSL - Revisão Sistemática da Literatura

TP - Trabalho de Parto

Vol. - Volume

RESUMO

A filosofia do Enfermeiro Especialista é estabelecer relação de confiança com a parturiente/acompanhante na continuidade de cuidados/manutenção da normalidade nos diversos estadios. A complexidade de atuação e a qualidade da exposição social aparecem condicionadas a fatores culturais/sociais que impedem de criar consciência coletiva sobre a essência do Cuidar no Bloco de Partos.

Recorreu-se à Revisão Sistemática da Literatura para responder à pergunta em formato PI[C]O: No Cuidar da Mulher em Trabalho de Parto, que competências o Enfermeiro Especialista em Enfermagem de Saúde Materna, Obstétrica e Ginecológica demonstra que desencadeie Empoderamento Social?

Teve como objetivo contribuir para a promoção do Empoderamento Social do Enfermeiro Especialista na aquisição de poder profissional e integração cognitiva do conceito pela sociedade.

Concluiu-se que o Enfermeiro Especialista em Saúde Materna, Obstétrica e Ginecológica deve utilizar as competências na finalidade da ação, assumindo atitudes clínicas que revelem autonomia e provoque reconhecimento da sua complexidade, contribuindo para o Empoderamento Social.

Palavras Chave: Enfermeiro Especialista em Saúde Materna e Obstétrica, Empoderamento Social, Competências**.**

ABSTRACT

It is the aim of nurses specialized in maternal, obstetrical and gynecologic health within midwifery, to establish a relationship of confidence among women, to ensure that women's long term care are provided and fulfilled under different given conditions. The uniqueness of the field of work, regarding the general and specific knowledges of nurse-midwives and the kind of social exposure constrained by social and cultural factors, prevent a collective awareness of the gist of care concerning midwives and maternity care in midwifery.

The empowerment of specific skills and knowledge borne by nurse-midwives, concerning the domain of professional power, along with the social acknowledgement in general, leads us to the question: Regarding care during labour which competences/skills does the nurse-midwife has to show, in order to be socially recognized?

Answered this question, it is very important to use this empowerment as a source of engagement and decision making in clinical situations, as well as in daily professional behaviors, that show autonomy, responsibility, respect and professional dignity.

Nurse-midwife's complex actions and varied knowledges can thus contribute to a personal, as well as collective conscientiousness of social empowerment in maternal, obstetric and gynecologic nursing.

Keywords: Nurses Specialized in Maternal, Obstetrical and Gynecologic, Social Empowerment, Competences/Skills

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INTRODUÇÃO

A Unidade Curricular Estágio IV e Relatório do 2º CMESMO da ESSS, foi desenvolvida no 2º semestre do 2º ano, entre 28 de outubro de 2013 e 4 de abril de 2014, na componente de ESMOG na Sala de Partos.

O ponto de partida para este percurso reflexivo e de construção do conhecimento especializado foi a análise de contexto do Estágio IV e RSL como técnica de pesquisa em enfermagem. Esta metodologia de reflexão sobre a prática surgiu da necessidade de demonstração das competências específicas do EEESMOG, em contexto de bloco de partos.

Ao longo dos tempos tem-se observado um aumento na complexidade dos problemas de saúde na área de ESMOG aos quais o EEESMOG tem que dar resposta de forma autónoma com sabedoria, criatividade, flexibilidade, inovação e produtividade. Estes desafios permanentes mostram-nos a filosofia estratégica do Empoderamento no domínio de Enfermagem, como natureza e arquitetura da ação da prática do cuidar em ESMOG, entendido como um processo social de reconhecimento, promoção e aumento de capacidade de identificação de necessidades e satisfação das mesmas, resolução de problemas e mobilização de recursos necessários no sentido de controlarem a sua atividade clínica (Gibson, 1991). Esta perspetiva pressupõe um processo de colaboração, cooperação e reciprocidade entre os envolvidos, nomeadamente o EEESMOG, a mulher e as entidades governamentais (Gibson, 1991). Portanto, entender que o EEESMOG possui um conjunto de conhecimentos, capacidades e habilidades que lhes permite ponderar as necessidades de saúde do grupo-alvo e atuar em conformidade com as CCEE e competências específicas do EEESMOG, elevou o nosso patamar de exigência pessoal e profissional ao qual quisemos dar uma resposta adequada.

Neste sentido, formulou-se uma questão de partida, segundo o formato PI[C]O: No Cuidar da Mulher em trabalho de parto que competências o EEESMOG demonstra que desencadeie Empoderamento Social?

Assim, este relatório procura contribuir para a promoção de empoderamento social (enquanto processo social de reconhecimento) do EEESMOG para um domínio de influência do poder profissional, integração cognitiva do conceito pela sociedade.

Eram objetivos preconizados para o Estágio: prestar cuidados especializados de enfermagem à parturiente e recém nascido em situação de saúde e doença; integrar a equipa de saúde prestadora de cuidados à parturiente e RN em situação de saúde e doença; aprofundar a análise reflexiva das atividades e intervenções desempenhadas com base nas CCEE e nas competências do EEESMOG; aprofundar conhecimentos que permitissem fundamentar a tomada de decisão e o julgamento clínico em ESMOG.

Para o Relatório de Estágio traçamos como objetivos:

- Identificar a singularidade do campo de atuação, a filosofia de cuidados e os padrões assistenciais da ESMOG em contexto de bloco de partos;
- Salientar as competências específicas do EEESMOG desenvolvidas em ação no bloco de partos, sustentando-as na natureza de Enfermagem Avançada;
- Identificar estratégias de mudança, como sejam, o Empoderamento Social do EEESMOG durante o processo de trabalho de parto;
- Enquadrar o Empoderamento Social do EEESMOG na Prática Baseada na Evidência e a sua sustentabilidade de mudança, com recurso à metodologia científica -RSL;
- Divulgar os resultados de ação/intervenção de enfermagem produtoras de resultados sensíveis ao Empoderamento Social do EEESMOG em contexto de bloco de partos;

Assim, este relatório está dividido em quatro partes. Na primeira, analisamos a natureza da problemática desenvolvida durante o Estágio IV; na segunda, desenvolvemos a definição de conceitos e o enquadramento teórico da problemática; na terceira, apresentamos a metodologia de pesquisa, onde analisamos e fundamentamos teoricamente as competências desenvolvidas e contributos para a melhoria dos cuidados em ESMOG e na quarta, apresentamos a conclusão e respetivas sugestões. Constam deste relatório todos os anexos inerentes ao percurso desenvolvido.

Apesar de ser comummente utilizado o termo ESMO e EEESMO, optou-se por manter a terminologia ESMOG e EEESMOG, conforme o Regulamento n.º 127/2011, publicado em Diário da República.

1. NATUREZA DA PROBLEMÁTICA - ANÁLISE DO CONTEXTO

O percurso formativo para aquisição do título de EEESMOG, foi assente na premissa que os cuidados de enfermagem tomam por foco de atenção a promoção dos projetos de saúde que cada mulher vive e persegue, em todo o ciclo de vida reprodutivo, inserida num ambiente familiar, social e político económico, de forma individual e coletiva (Regulamento n.º 127/2011).

Segundo a Ordem dos Enfermeiros (2011), o EEESMOG integra no seu exercício profissional intervenções autónomas nos processos fisiológicos de baixo risco e intervenções interdependentes nos processos patológicos de médio e alto risco do ciclo de vida reprodutivo da mulher. Nesta ordem de ideias, a acreditação (entendido como autorização para exercer uma atividade), (dicionário de língua portuguesa), do EEESMOG é garantida por competências científicas, humanas, de destreza intelectual e técnica e por um processo reflexivo sistemático sobre a prática de enfermagem capaz de promover o seu contínuo desenvolvimento (Serrano, Costa e Costa, 2011).

Foi nesta conjuntura que se refletiu sobre todo o processo de aprendizagem que culminou com o Estágio IV - Enfermagem em Saúde Materna e Obstétrica na Sala de Partos, e entendeu-se a construção de cenários para ação no alargamento do campo de análise e a possibilidade da sua compreensão de forma sistemática e contextualizada na prática (Bernardino, 2007).

Durante o percurso profissional sempre sentimos uma inquietude relativamente à prática de cuidados de enfermagem: por ser uma área específica de saberes que integra a complexidade de cada pessoa e procura constantemente a satisfação das suas necessidades; no que concerne à sua ação autónoma e à visibilidade das suas práticas. O confronto do nosso desenvolvimento pessoal com o desenvolvimento profissional e a reflexão sobre a qualidade da nossa exposição social, ganhou outro ânimo após a especialização nesta área.

Ao longo da formação especializada, a nossa ação ganhou contornos autónomos no campo de saberes de ESMOG, congregando na nossa prática diária para além das competências de cuidados gerais aquelas que decorreram do desenvolvimento de competências diferenciadas. E este complemento à formação base mostrou-se de suma importância no nosso percurso pessoal e profissional, justamente pelo domínio aprofundado desta área específica, que nos confere uma autonomia definida pela legislação em vigor (Regulamento n.º 127/2011).

No contexto do BP a equipa de ESMOG desenvolve uma prática profissional reconhecida pela instituição governamental que possibilita um trabalho multidisciplinar e uma participação na tomada de decisão, processo este que a equipa realiza diariamente quando tira considerações específicas do seu campo de atuação, fazendo valer as suas competências através da gestão das dificuldades sentidas (Banning, 2007).

Não obstante da profissão ter reconhecimento das instituições governamentais pelo crescente número de licenciados, mestres e doutores, pela inclusão do curso de enfermagem no ensino universitário, da representação nos conselhos administrativos, da visível melhoria dos cuidados de enfermagem prestados, fruto da investigação nas ciências de enfermagem, não existe, segundo Ribeiro (2009), visibilidade social da profissão nem o devido reconhecimento pelos outros profissionais. De acordo com Amendoeira (2004), os enfermeiros têm cada vez mais clara a percepção das suas capacidades, das qualificações e das competências que desenvolvem quotidianamente, mas têm dificuldade em assumir um papel mais significativo na construção e no desenvolvimento de uma profissão autónoma.

Neste sentido, Nunes (2006), refere ainda que o atual percurso foi realizado considerando que a colaboração multiprofissional é uma das nossas funções e que trás consigo o respeito pela autonomia de cada parte envolvida, mesmo na execução de funções interdependentes, em que dado o caráter de continuidade dos cuidados, assume a nossa profissionalidade resultante do empenho dos profissionais em atitudes e ações positivas na sua produtividade, principalmente aos olhos da gestão governamental. Assim, a interdisciplinaridade permite o ganho de estatuto da enfermagem como disciplina, arte e ciência e fortalece-nos como profissão (Amendoeira, 2004).

Contudo, não podemos deixar de salientar que, na grande maioria, os Enfermeiros do BP são especialistas na área de ESMOG e que esta situação intensificou a nossa aprendizagem e a consciencialização da potencialidade dos cuidados prestados. Intensificou, porque espelhamo-nos nas competências do EEESMOG durante o percurso formativo e consciencializamo-nos da sua potencialidade, porque efetivamente traduzem ganhos em saúde (PORDATA, 2015) e revelam-se prósperos a uma melhoria contínua, pois envolvem múltiplas atividades e atributos que influenciam os resultados dos cuidados, dos clientes e do hospital (Teitel, 2002, citado por Ribeiro, 2009).

Ribeiro (2009), demonstra que o EEESMOG que expressa maior perceção de autonomia profissional manifesta-se mais satisfeito com a profissão e revela maior capacidade de tomada de decisão no contexto de trabalho. Desta forma, sentimos que aquilo que suscita gratificação no desempenho de ESMOG é o espaço de atuação decorrente das competências regulamentadas, que permite uma prestação de cuidados autónoma dentro dos limites profissionais. Pretendemos no entanto que este agir autónomo não se limite à esfera do grupo profissional, mas que promova um reconhecimento social do mesmo pois, no Estágio IV, percepcionamos que o EEESMOG carece de uma maior visibilidade e de reconhecimento das suas reais competências pela sociedade. Tal facto reflete um desfasamento entre as competências que o EEESMOG demonstra e a perspetiva das mesmas pela parturiente/acompanhante. Ou seja, mais do que a parturiente/acompanhante identificar as competências do EEESMOG, será a sua aceitação e valorização social enquanto legítimo que objetivamos.

Posto isto, pretendemos estudar a temática do empoderamento do EEESMOG e como o Empoderamento Social do mesmo pode modificar a representatividade da ESMOG enquanto profissão.

Passamos então a tentar compreender a problemática com factos da prática.

O alvo de cuidados de enfermagem no BP é a mulher na condição de parturiente e puérpera, o feto e RN e o pai/acompanhante. O EEESMOG assume responsabilidade pelo diagnóstico diferencial no âmbito do autocontrolo do TP, ligação mãe/pai- filho, adaptação à parentalidade e pela detecção precoce de complicações e referenciação atempada de complicações materno fetais durante o TP, parto e puerpério imediato (Regulamento n.º 127/2011).

O trabalho de parto, parto e puerpério imediato são momentos decisivos para a parturiente/acompanhante pois encerram o ciclo da gravidez e iniciam uma nova dimensão de papéis onde todas as situações são vivenciadas de forma distinta e particular. De salientar que, quando nos referimos ao processo de cuidados em BP, incluímos o momento de vigilância materno fetal durante o TP, o momento do parto e o puerpério imediato/ vigilância do RN.

No contexto da prática, sentimos que exercemos controlo sobre o processo de cuidados de cada parturiente/acompanhante, uma vez que, a partir do momento que são admitidas no serviço de BP, assumimos responsabilidade pelos cuidados prestados. Exatamente por sermos o grupo profissional que está em permanência nos serviços de saúde asseguramos a prestação de cuidados de enfermagem de domínio especializado em ESMOG e articulamos os cuidados prestados no seio da equipa multidisciplinar. Ouvimos frequentemente os enfermeiros referirem " nós fazemos tudo", no sentido do desabafo, mas na realidade sublinha que a gestão do processo de cuidados é feita pelo próprio, independentemente das suas ações autónomas ou interdependentes.

Assim verificou-se que, em todo o processo de cuidados, desde o acolhimento no bloco de partos até à transferência da puérpera/RN para o puerpério, as vigilâncias de TP, parto e puerpério imediato foram alvo da nossa intervenção autónoma em ESMOG. Ainda neste sentido, foi recorrente a parturiente/acompanhante questionar esta autonomia durante todo o processo, deixando transparecer expressão de admiração e desconhecimento. Este facto fez-nos questionar sobre o porquê deste comportamento uma vez que o processo de cuidados desenvolvia-se de forma personalizada e ajustada à autonomia clínica que o EEESMOG detém.

As situações clínicas de TP que resultaram em parto distócico foram também conduzidas por nós até ao limite das nossas funções autónomas, encaminhando a situação por forma a garantir a segurança dos cuidados, articulando e demonstrando sempre as nossas competências mesmo nas funções interdependentes.

Curiosamente, a mesma questão foi formulada por parturientes enfermeiras de profissão. De salientar que, exerciam em áreas de enfermagem distintas, que não a ESMOG e que neste estadio, prevaleceu o papel de mãe e o bem estar materno-fetal. Como refere Stern e BruschWeiller Stern (2000), citado por Monforte e Mineiro (2006), o receio da chegada do momento do parto e os receios acerca da saúde do RN dominam os pensamentos da parturiente/acompanhante pois este período, como acrescenta Cruz (1990), é vivido como um momento irreversível, imprevisível e desconhecido. De qualquer forma, se dentro da própria classe surge o desconhecimento das habilidades profissionais e da autonomia profissional, sugere-nos que este poderá ser abrangente na sociedade.

A expressão/referência de desconhecimento e admiração foi tida em vários momentos do TP nomeadamente no momento do acolhimento no bloco de partos (em alguns serviços a sala de dilatação), nas situações de prolongamento de estadios de TP, em situações de dor/desconforto intenso e no período que antecipa imediatamente o período de expulsão. No puerpério imediato esta situação não se fez sentir. Este facto fez-nos entender os momentos chave da visibilidade das competências do EEESMOG, nomeadamente o momento do parto e as situações de desconforto intenso/prolongamento do 2º estadio de TP.

Neste sentido, continuamos a estar perante um sistema de saúde que se move pelo sentido de doença e onde a sociedade não reconhece a prestação de cuidados nos processos de TP de baixo risco como um processo fisiológico normal do nascimento (Ulrich, Soeken e Miller, 2003). Contudo, acreditamos que a parturiente/acompanhante tem o direito de vivenciar o parto como momento único, personalizado segundo as suas crenças, valores, costumes e de dinâmica familiar, de forma a fortalecer os aspetos do processo fisiológico normal do nascimento (Sardo, 2012, citado pela OE, 2012), desconstruindo o sentido de doença face ao TP. Idealmente, consoante afirma Emming (2000), citado por Fialho (2008), e conforme recomenda a OMS (1996), a parturiente deve encarar o TP e parto como um ato espontâneo de "dar à luz", sem considerá-lo como ato médico, com necessidade de grandes intervenções.

Se a intencionalidade do processo de cuidados é promover a vivência positiva do processo fisiológico do TP, parto e puerpério imediato, uma infinidade de cuidados têm que ser integrados na esfera de ESMOG. Em contexto de bloco de partos, as individualidades parturiente, pai/acompanhante e RN, são inseridos nessa esfera procurando um verdadeiro equilíbrio. Este equilíbrio advém de um conhecimento aprofundado relativo a este campo de atuação que, perante as respostas humanas aos processos de vida e aos problemas de saúde, demonstramos níveis elevados de julgamento clínico e tomada de decisão que validam as nossas competências especializadas. Ou seja, a nossa prática enquanto EEESMOG foi complexa e exigiu a cada momento, mediante cada situação, a mobilização de vários saberes, mantendo a ideia do saber especializado e da ação como um todo complexo (Simões, 2008).

A prática autónoma em ESMOG consistiu em aplicar o processo de enfermagem de forma auto dirigida, uma vez que a ação foi auto determinada, controlada e não mereceu a autorização de outra pessoa. Todo este processo foi caraterizado pelo facto de identificar um problema ou um potencial problema que nós enquanto EEESMOG podemos dar resposta eficiente e eficaz (Ribeiro, 2009), representando a liberdade de tomar decisões vinculativas baseadas nos conhecimentos clínicos e perícia dentro do âmbito da prática (Ribeiro, 2009). Compreende-se pois, que possuímos conhecimentos específicos que nos permite identificar, diagnosticar, planear, implementar e avaliar os cuidados que nós próprios controlamos e executamos, conferindo-nos autonomia.

Mais acrescenta Lyon (2005), citado por Ribeiro (2009), que o processo de enfermagem é tão mais autónomo quanto maior for a responsabilidade para a ação, sendo necessário para ditar uma resposta ao problema identificado, problema este que a autora definiu como fenómeno. Assim, durante o Estágio IV controlamos o fenómeno que caiu dentro do domínio único de

ESMOG, uma vez que é o fenómeno que o EEESMOG trata de forma autónoma que define a essência de ESMOG e o âmbito da própria prática.

Neste contexto, assumimos responsabilidade pelo exercício nas áreas de atividade de intervenção do parto (assistência à mulher a vivenciar os processos de saúde/doença durante o TP e parto) e cumprimos as nossas funções autónomas e interdependentes conforme define o regulamento de competências específicas do EEESMOG, articulando os processos com os demais profissionais, subjacente à interdependência das profissões (Regulamento n.º 127/2011), sempre com resultados optimizados, uma vez que, a taxa de mortalidade materna em 2013 foi de 6% (em cada 100.000 nascimentos), com uma média nos últimos 15 anos de 5,3%, havendo inclusive anos como em 2000 e 2005, que rondou os 2,5% (Pordata, 2015). Relativamente à taxa de mortalidade infantil, em 2014 foi de 2,8%, sendo uma das melhores taxas em todo o mundo (DGS, 2015).

No entanto, para que o processo de autonomia se instaurasse, houve habilidades como a autoconfiança, a autodeterminação, o autoconhecimento, que em conjunto com as competências científicas, relacionais e técnicas produziram o Cuidar em ESMOG, assentes em segurança e qualidade. O desenvolvimento de competências cognitivas (saber), psicomotoras (saber-fazer), sócio-afetivas, relacionais e ético-morais (saber-ser), (Dias, 2006), dependeram do processo reflexivo sobre a prática clínica adequando a forma como interviemos em cada situação (Graveto, 2005), numa perspetiva de continuidade.

Deste modo, garantimos que a parturiente/acompanhante vivenciasse o momento do parto segundo a sua ideologia, vencendo os medos, proporcionando auto estima, e incentivando ao auto controle da situação, mostrando versatilidade e criatividade do ponto de vista humano e relacional enquanto EEESMOG e do saber oriundo da prática, que ao longo da atividade profissional e agora acrescida da formação especializada, acarretou perícia e sabedoria, características ímpares nesta área do saber.

A prestação de cuidados em ESMOG ocorre sempre no contexto de uma interação, em que provemos sobre as escolhas a serem feitas, envolvendo julgamentos constantes, que implicam valores, normas e interesses, orientando o exercício do saber em contexto de trabalho. Portanto, entender a parturiente/acompanhante, no momento que vivenciam, resulta de um desenvolvimento contínuo e sistemático do saber científico, do saber da prática e do saber pessoal. Este último, segundo Carper (1978), citado por Simões (2008) compreende a experiência interior de tornar-se um todo, de conhecer-se a si próprio.

Neste campo, o Saber pessoal é essencial na prática enquanto EEESMOG, uma vez que, como em qualquer relação interpessoal, as interações beneficiam com o modo como nos apresentamos. O facto de sermos comunicativos, atenciosos, cativantes, criativos e simpáticos (característica tantas vezes enumerada), capta a atenção da parturiente/acompanhante e desenvolve uma relação empática, que em tudo beneficia a prestação de cuidados e cria laços interpessoais importantes. Neste sentido, há determinadas características pessoais imprescindíveis, que traçam o perfil do EEESMOG e que realçam a diferença de uma prestação de cuidados diferenciada, madura e responsável, que a longo prazo trará sabedoria e perícia.

Sempre que a parturiente/acompanhante era admitida, realizava-se a apresentação da unidade, da equipa responsável, informava-se sobre os procedimentos que iriam ocorrer, as alterações fisiológicas e a dinâmica da vigilância de TP. Incentivou-se sempre a presença e proatividade do acompanhante e certificou-se que a parturiente encontrava-se cómoda, esclarecida e motivada para a gestão do seu processo de saúde. Segundo Fialho (2008), o EEESMOG deve conhecer a situação da parturiente para poder interpretar e obter uma compreensão informada das necessidades sensíveis aos cuidados de enfermagem. Essa compreensão objetivou selecionar estratégias adequadas para resolver os problemas identificados.

Portanto, foi realizado nos vários momentos de interação/intervenção, com a parturiente/acompanhante, a promoção de um ambiente acolhedor e favorável ao processo de cuidados; escuta ativa e procura constante de empatia; negociação do processo de saúde e estabelecimento de parceria no planeamento de cuidados, com promoção da tomada de decisão e participação ativa nas ações planeadas; esclarecimento constante de procedimentos tendo em vista minimizar o impacto negativo, provocado pela mudança de ambiente e de condição de saúde; fornecimento de informação geradora de aprendizagem cognitiva e de novas capacidades; promoção da interação parturiente/acompanhante; satisfação das suas necessidades, respeitando as suas crenças, valores e desejos de natureza individual, como expectativas em relação ao TP e ao projeto de maternidade/paternidade. Também foi difundida a promoção de estilos de vida saudáveis no puerpério imediato assim como, a promoção do potencial de saúde da parturiente/puérpera, avaliação dos recursos existentes e a sua adaptação às necessidades.

Mais uma vez, rompeu-se com uma praxis, nos momentos de interação com a parturiente/acompanhante, uma vez que, não nos resumimos a momentos standardizados de transmissão de informação, mas procurou-se ajustar a conduta protocolar às necessidades da parturiente/acompanhante. Foram momentos privilegiados de interação, alicerçados na construção de um sentimento de confiança, (e assim atenuadora do impacto do desconhecido), que deu lugar à elaboração de um plano de cuidados necessário ao cuidar personalizado. Utilizou-se também uma linguagem uniforme e universal, reconhecida pela equipa multidisciplinar, o que permitiu compreender e contextualizar a prática de cuidar em ESMOG. Contudo, a singularidade de cuidar em ESMOG prevê uma linguagem própria, que se recria pela CIPE (Classificação Internacional para a Prática de Enfermagem), pela sua arquitetura de ação alicerçada em Modelos Teóricos de Enfermagem e pela clarificação e visibilidade atribuídas à natureza de ação em ESMOG - a ação autónoma.

Fialho (2008) refere que, embora haja evidência científica suficiente para que se realize modificação nos cuidados de saúde no TP de baixo risco com tendência para o modelo biomédico, desmedicalizá-lo significa para muitas realidades perda de poder. Abandonar dinâmicas que adequam o TP ao modo de funcionamento hospitalar e adotar medidas que privilegiam o acompanhamento fisiológico seria, segundo Dias e Domingos (2005), perder o controlo biomédico no processo de TP de baixo risco e modificar as referências do sistema de saúde.

Posto isto, a parturiente/acompanhante não demonstrou valorizar e perceber o domínio do EEESMOG na gestão do seu processo de saúde, capaz de criar uma consciência coletiva do seu perfil de competências.

Em relação ao trabalho de equipa no seio da equipa de ESMOG, este mostrou-se sempre proativo, participativo em todas as situações do serviço, de partilha de conhecimentos e interajuda e com períodos de reflexão sobre as atividades realizadas. Mas foram perante estes momentos que se realçaram as características pessoais e profissionais do grupo, que nos permitiram aprofundar competências na gestão dos recursos humanos, materiais, interrelacionais, de supervisão e liderança.

Outro ponto a salientar foi a diferente expressão de autonomia funcional no seio da equipa de ESMOG. Justamente por sentirmos a autonomia parte integrante da ESMOG e fundamental para o reconhecimento da profissão/especialidade pela sociedade, desenvolvemos esta componente ao longo do Estágio IV de forma criteriosa, e ao qual consideramos ter obtido resultados sensíveis à prática de ESMOG e fortes contributos para a resolução da problemática em estudo, com base na PBE. Assim, identificou-se diferentes estádios de atitude clínica e tomada de decisão na resolução de situações. Perante os mesmos fatores desencadeantes de problemas de enfermagem, eram tomadas decisões mais autónomas ou mais interdependentes, consoante o EEESMOG responsável. Ou seja, o limiar da autonomia mostrou-se ainda ténue. Estas situações associam-se a características pessoais, culturais e sociais (motivação pessoal, valorização profissional e conquista de autonomia pessoal/profissional) e não aparentemente ao tempo de exercício profissional e/ou de especialização.

Nesta lógica, Mendes (1999), citado por Ribeiro (2009), refere que a autonomia pode ser incómoda, não só porque é mais exigente e mais responsabilizadora, mas também porque exige um empenho capaz de conduzir ao reconhecimento dessa autonomia pela sociedade em geral. Ribeiro (2009), acrescenta que na própria classe existem membros que apresentam comportamentos contraditórios à autonomia pois não se sentem à altura das exigências e responsabilidade pedidas. É necessário por isso que, o EEESMOG queira e saiba assumir esta forma de estar na profissão, consentâneo com a exigência de um agir autónomo, nomeadamente pelo conhecimento, profissionalismo, responsabilidade, ou seja, pela competência no que fazem e também no discurso que produzem (Mendes, 1999, citado por Ribeiro, 2009), sendo esta situação geradora, sobretudo, de satisfação profissional, motivação e empenho, logo num aumento da qualidade dos cuidados prestados.

Neste sentido, o EEESMOG competente não é aquele que tem os recursos, mas aquele que, articulando os seus vários domínios, consegue mobilizá-los (Le Boterf, 2003). Contudo, o desenvolvimento profissional passa obrigatoriamente por um desenvolvimento pessoal e a formação é apenas um elo da cadeia (Hesbeen, 2001).

Relativamente ao trabalho de equipa multidisciplinar, consideramos que existe respeito pelas competências do EEESMOG, o que nos permitiu um agir proativo em todas as situações clínicas que compõem o serviço e possibilitou uma equidade nas funções autónomas e interdependentes mesmo enquanto formanda. A validação pelos pares das competências

apresentadas foi uma constante. No entanto, estes momentos eram mais ou menos marcantes consoante a atitude clínica do EEESMOG, ou seja, perante um EESMOG com competências reconhecidas pela equipa e pelos pares, a interação interprofissional era de homogeneidade e de continuidade de cuidados de saúde em equipa. Doutra forma, a continuidade dos cuidados, passava por uma reavaliação da situação realçando os limites de intervenção pelo poder profissional. Podemos afirmar que, a nossa prestação de cuidados enquanto formanda, foi reconhecida pelos pares, tendo por isso trabalhado o Saber Científico, o Saber da Prática e o Saber Pessoal, fazendo emergir a nossa identidade profissional como EEESMOG.

Nesta linha de pensamento, partilhamos da opinião de Araújo (2008), quando refere que a identidade profissional e a imagem social constrói-se na interação de dois planos: o plano dos profissionais que se auto reconhecem no desempenho das suas atividades e o plano do reconhecimento desse papel por parte dos outros que com eles se relacionam. Contudo, como todas as formas de saber são efémeras e temporárias, é importante desenvolver competências transversais, isto é, competências que envolvam a capacidade de reflexão, de análise do contexto da prática, de pensamento crítico e saberes-fazer em contexto de trabalho (Serrano *et al*., 2011).

Nesta sequência, assumimos, conforme refere Wiens (1990), citado por Ribeiro (2009), que somos autónomos para escolher quando o controlo deve ser retido ou renunciado e termos autonomia não significa que tenhamos controlo total sobre as situações mas que temos a capacidade de cumprir as nossas funções profissionais numa forma autodeterminada enquanto cumprimos os propósitos legais, éticos e práticos da profissão. Devemos encarar autonomia como consequência dos atributos de uma profissão, logo da ESMOG e como condição para a obtenção dessa autonomia (Freidson, 1970). Nesse sentido, clarificou-se em todos os momentos da interação com a parturiente/acompanhante, a dinâmica do serviço, a competência e o papel da equipa de ESMOG e da equipa multidisciplinar, garantindo cuidados de saúde qualificados, seguros e de qualidade. Perante estas situações, ao longo da vigilância do TP foi notório um ganho de confiança na segurança dos cuidados de saúde por nós prestados, após o esclarecimento sobre as nossas competências, mas sobretudo após a vivência na integra do processo de cuidados. Após este processo não foi registado em nenhuma situação de parto eutócico realizado pelo EEESMOG fragilidades emocionais, técnicas e humanas por parte da parturiente/acompanhante.

Por outro lado, quando as situações de TP de baixo risco evoluíam para um parto distócico e logo, de partilha de competências interprofissionais a parturiente/acompanhante demonstrou um sentimento de insegurança perante a evolução do TP, por associar aumento de risco clínico. Segundo Osava (2003), citado por Fialho (2008), o nascimento cria representações muito fortes acerca de sentimentos de insegurança que envolve o TP uma vez que, como acrescenta Tornquist (2003), citado por Fialho (2008), a parturiente no momento do parto passa a preocupar-se com o seu desempenho, com o controlo de emoções, e necessita de reencontrar a sua autonomia e autoconfiança. Nestas situações, houve demonstração verbal e não verbal frequente da necessidade da nossa presença, enquanto EEESMOG na continuidade do processo de cuidados. Isto é, sempre que houve situações de partos distócicos por via vaginal ou Cesariana, as

parturientes/acompanhantes manifestaram interesse em nos manter presentes, perguntando se ficávamos a acompanhar a situação e pediam o nosso apoio durante todo o processo, como elo de ligação e como garantia de sensação de segurança e conforto.

Este comportamento demonstrado apresentou pouca relação entre idade e escolaridade, apesar de haver um predomínio nas parturientes de extremos da idade reprodutiva. Apenas a multiparidade e a existência de uma vigilância pré-natal realizada pelo EEESMOG demonstraram ser coniventes com o reconhecimento das competências do mesmo, pressupondo que a experiência anterior produziu resultados positivos às nossas competências. Foi também identificado que a representatividade das nossas competências em ESMOG é associada maioritariamente à componente relacional e humana encerrando nesse circuito o reconhecimento das restantes componentes.

De todos os contextos de ação e áreas de intervenção do EEESMOG identificamos que, no contexto de bloco de partos, a competência que foi mais verbalizada foi sobretudo a técnica, uma vez que, a parturiente dá primazia ao momento técnico do parto.

A competência relacional esteve sempre subjacente ao cuidar em enfermagem e essa componente é reconhecida socialmente. Contudo, mais do que a parte relacional, é a competência técnica e científica que surge com a especialidade em ESMOG e que dá subsídios ao caminho a percorrer no reconhecimento social do EEESMOG. Em muitas situações as parturientes referiram-se à componente relacional mas nunca especificamente às restantes. Ficou implícito nos seus discursos de agradecimento pelo momento do parto e de satisfação perante todo o processo de cuidados que reconheciam as nossas competências técnicas e científicas. Mas o facto de não as referirem pode significar que não as interiorizaram e logo não irão produzir consciência pessoal, colectiva e social das competências do EEESMOG.

Portanto, ao longo do Estágio IV foram registadas estas ocorrências que causaram inquietação e necessidade de proceder à análise das mesmas. Neste sentido, considerou-se prioritário avaliar a forma através do qual o EEESMOG demonstra à parturiente/acompanhante as suas competências e se estes consideram uma mais valia o seu desempenho, ou seja, se os resultados da prestação de cuidados são sensíveis às competências do EEESMOG.

À parte da aceitação da parturiente/acompanhante à realização do TP e parto pelo EEESMOG, identificou-se a falta de promoção/divulgação das nossas competências que constitua um percursor de aceitação social. Pensamos que, o ponto fundamental não se trata da satisfação perante os cuidados prestados mas sim a identificação/interiorização/ divulgação por parte da parturiente/acompanhante das competências e autonomia do EEESMOG em todo o processo.

Nesta trajetória, muito contribui a aquisição de competências científicas, que classificam o desenvolvimento da disciplina de Enfermagem e consequentemente a carreira do EEESMOG. Todavia, apesar deste longo percurso em licenciar a disciplina de Enfermagem, não houve um percursor de aceitação social capaz de criar uma consciência coletiva da representação social do EEESMOG (Sêga, 2000).

A OE (2011) definiu um enquadramento regulador para a certificação das competências do EEESMOG e os seus domínios de intervenção. Curiosamente, um momento da finalidade do perfil

de competências aponta para o dever de comunicar aos cidadãos o que podem esperar deste grupo profissional (Regulamento n.º 127/2011). Partindo do pressuposto que comunicar significa ação de dar a conhecer, divulgar ou informar, expor, notificar ou veicular informação relevante (dicionário de português), entendemos que é da nossa competência enquanto EEESMOG dar a conhecer as aptidões que caraterizam e habilitam a desempenhar a nossa função com qualidade e excelência.

Ainda assim, a própria OE (2011), sentiu essa fragilidade representativa na sociedade e incentiva a combater essa lacuna através da divulgação das competências do EEESMOG. Neste sentido, estamos perante um processo de colaboração entre os intervenientes do processo, sejam eles os profissionais, os clientes e as instituições. Visto que esta parceria de cuidados já existe, cabe ao grupo de profissionais de ESMOG ir ao encontro das suas necessidades e mobilizar os seus próprios recursos para produzirem resultados sensíveis ao reconhecimento social da profissão, utilizando para tal o Empoderamento.

Em tempos que o Empoderamento está na ordem do dia, como forte aposta na "capacitação dos cidadãos" (PNS 2011 - 2016) e, sendo uma área prioritária de investigação em Enfermagem em Portugal (OE, 2010), deve ser preocupação compreender se o EEESMOG está dentro da filosofia do Empoderamento, utilizando-o para capacitar-se no sentido de promover um processo social de reconhecimento e promoção das suas competências (Empoderamento Social). Por outro lado, e fazendo jus à competência do EEESMOG de comunicar, pensamos que essa seja a chave para o reconhecimento e atribuição de uma representação social.

Assim, este Relatório de Estágio propõe-se explicar a prioridade desta temática e a sua urgência interventiva em produzir resultados sensíveis ao Empoderamento Social do EEESMOG.

2. ENQUADRAMENTO DA PROBLEMÁTICA

A aquisição da especialidade em ESMOG revelou-se uma oportunidade de crescimento e de obtenção; alargamento e reforço de poder (entendido como influência para a ação ou resultado (Cunha, 1992), na gestão do processo de saúde de cada parturiente/acompanhante, perante as competências científicas, técnicas, humanas e ético morais aprofundadas. Contribuiu também para intensificar o percurso reflexivo e identificar a problemática em estudo, como seja: a importância dos cuidados de enfermagem especializados em ESMOG, na vivência do processo de TP e parto pela parturiente/acompanhante, e que impacto social demonstram para o seu verdadeiro reconhecimento e valorização. Falaremos de parturiente/acompanhante, uma vez que o estudo incide sobre o contexto de ação do bloco de partos e nomeadamente no momento de trabalho de parto, parto e puerpério imediato.

Neste estadio, não restam dúvidas de que a produção de conhecimentos em Enfermagem e em ESMOG tem determinado um constructo científico que contribui para a qualidade, eficácia e eficiência dos cuidados de saúde, aumentando a credibilidade da profissão.

Por outro lado, o EEESMOG procura o reconhecimento das suas competências e do conteúdo funcional que sustenta as suas ações, como se estas não fossem identificáveis e reconhecíveis socialmente. Sobre esta problemática, Hesbeen (2000), citado por Araújo (2008, p.44) salienta que, mais do que procurar a semântica do seu conteúdo funcional, "é importante desenvolver estratégias que espelhem o que muitas vezes parece implícito mas invisível a um senso comum profissional e social".

Leal (2006), relata que o EEESMOG deve ter presente que a visibilidade de uma profissão apenas revela a realidade. Desta forma, deve conferir maior relevo àquilo que é a sua atividade autónoma e demonstrar que a ESMOG por si só, é relevante para melhorar a saúde das populações.

Para analisar esta temática, parece importante relembrar o percurso histórico da ESMOG e relatar qual foi o processo de construção social que a profissão vivenciou, assim como os domínios e contributos da especialidade em ESMOG. Intrinsecamente ligado a este tema assenta a necessidade de mostrar a insubstitualidade da prática de ESMOG e a necessidade do seu reconhecimento social, como parte integrante do Empoderamento Social do EEESMOG.

2.1. PERSPETIVA HISTÓRICA E SOCIOANTROPOLÓGICA DA PROFISSÃO

Cuidar sempre foi o propósito de Enfermagem. Porém, o percurso que fez emergir as especificidades deste conceito através da construção de uma base científica e de uma metodologia capaz de disciplinar a Enfermagem, merece reflexão.

Para Simões (2008), é inquestionável que o Cuidar em ESMOG desempenhe um papel central na resposta às necessidades concretas de cada mulher, independentemente da sua situação/problema ou do contexto em que se desenrola a ação.

Como refere Nunes (2006), a Enfermagem era uma profissão de uma centralidade feminina ligada a um papel estereotipado, que conferia a imagem social de uma prestação de cuidados com um agir autónomo incipiente. Na área de ESMOG este papel estereotipado teve maior relevância e predomínio pois, intrinsecamente ligado ao cuidar como uma necessidade social, a parteira contribuía para o desenvolvimento da vida. A sua prática, oriunda de um saber empírico, passado de gerações em gerações, desenvolvia-se em torno de um conjunto de atividades para assegurar algumas necessidades fundamentais durante a gravidez, parto e pós-parto.

Em retrospetiva, a história de Enfermagem tem vindo a ser escrita de forma lenta e com regressões constantes que impediram a formação avançada em Enfermagem e a construção da disciplina até ao início do século XX.

Clarificar a prática e a natureza dos cuidados de Enfermagem deu a Florence Nightingale a primazia de objetivar a base da identidade da profissão, seguindo-se o desenvolvimento do conhecimento que fundamentou a prática e a legitimou como ciência, arte e disciplina (Tomey e Alligood, 2003).

A atividade profissional do EEESMOG, outrora parteira, foi considerado ofício desde a Idade Média. A parteira surgiu como necessidade social, pois tomava conta das mulheres em trabalho de parto, ajudava no parto e nos cuidados ao recém nascido. No fundo, a sua prática desenvolvia-se em torno de um conjunto de atividades para assegurar algumas necessidades fundamentais durante a gravidez, parto e pós -parto (Galhardo, 2004). O seu saber era empírico, adquirido pela experiência e como descreve Collière (1999), deslocavam-se de casa em casa, sem acesso a livros, nem a qualquer formação, exercendo durante séculos uma medicina sem diploma. Constituíram os seus saberes umas com as outras, transferindo-os no espaço e no tempo, de vizinha a vizinha, de mãe para filha. Socialmente, estas mulheres tinham um estatuto reconhecido por toda a comunidade, fundado no prestígio da sua experiência, exercendo a sua atividade de forma autónoma ainda há 50 anos.

A partir do Séc. XVI o reconhecimento dos saberes e das capacidades práticas da parteira conduziu a uma legitimidade corporativa pelo poder político, regulando-se o exercício da arte de partejar (ação transitiva de ajudar a nascer que se concretiza na ajuda prestada à parturiente pela parteira, no ato de parir), (Carneiro, 2008).

Mais tarde, as mudanças sociais em torno do papel da mulher na sociedade e o domínio da Igreja Cristã implementaram uma nova conceção sobre as práticas ligadas ao corpo e a institucionalização da medicina como saber formal veio sobrepor-se ao saber tradicional, incorporando-o como especialidade do saber médico. O saber da parteira foi relegado para segundo plano e o seu exercício passou a ser tutelado pela medicina, que determinou algumas exigências relativamente à sua formação e prática. Foi-lhes exigida formação adequada, com definição rigorosa dos quadros teóricos e práticos (Galhardo, 2004), sempre sob a subserviência médica.

Desta feita, o aprofundamento e diversificação do campo de saberes da medicina conferiu relações de poder e de saber, com a adoção do modelo biomédico, que atuou em dois níveis, o disciplinador e o regulamentador, através da instituição da "norma" (Carneiro, 2008). Segundo o mesmo autor, o campo do conhecimento das práticas do parto e maternidade inseriu-se gradualmente num domínio vasto e articulado que envolveu todas as etapas do ciclo de reprodução biológico e desqualificou os saberes tradicionais da parteira. A hospitalização do parto veio promover a reconfiguração da formação do EEESMOG e condicionar o domínio e reconhecimento da profissão, a extensão e natureza dos seus saberes, pelas relações de poder instauradas. Por outro lado, a partir da institucionalização da formação nas escolas médicas, a ausência de saberes teóricos aprofundados na formação do EEESMOG, bem como, a inexistência de condições para a sua produção, constituiu o argumento médico recorrente para serem determinados limites à sua ação.

Do ponto de vista sócio político, as desigualdades no acesso à saúde, um sistema de saúde fragmentado, indicadores sócio económicos e indicadores de saúde reprodutiva desfavoráveis tornou premente a expansão da rede hospitalar e a consagração do SNS (Lei n.º 56/79 de 15/9 da Constituição de 1979) de forma a melhor satisfazer as necessidades das populações.

Ainda na sequência de mudanças políticas, uma estratégia que revolucionou o estado da saúde em Portugal na área de ESMOG foi o PNSMI, iniciado em 1989 pela então CNSMI (Despacho 8/89), que assegurou o acesso equitativo à vigilância da grávida, puérpera, RN, criança e adolescente, com soluções estruturais indispensáveis designadamente, instalações, recursos humanos, dos quais EEESMOG, e equipamentos. Na sequência destas medidas, hierarquizou-se os hospitais em HAP e HAPD, que em conjunto com os centros de saúde integraram as RRMI desde 2001, sendo coordenado e articulado o seu funcionamento pelas UCF (Comissão Nacional de Saúde Materna e Neonatal, 2006), elevando-se o padrão de qualidade e segurança nos cuidados de saúde, sendo que para tal, foi fundamental a existência e a participação ativa do EEESMOG. Neste sentido, as estratégias suplantaram a garantia de segurança e qualidade no parto e nascimento, concretizando-se numa ascensão positiva de indicadores de saúde reprodutiva, nomeadamente na diminuição das taxas de mortalidade neonatal e materna (DGS, 2015).

Ao longo da história de ESMOG há a considerar diversas designações profissionais, modelos de formação e ainda os contextos institucionais que lhes estão subjacentes**.** De salientar

que, o modelo de formação apresentado pela Confederação Internacional das Parteiras (ICM) integra a profissão de parteira como um ramo da saúde com formação específica, baseada em Competências Essenciais para a Prática Básica da Profissão de Parteira, bem como, no quadro dos Padrões Globais para a Educação da Parteira (OE, 2015). Assim, a parteira é alguém que, demonstra competências para a prática da profissão, após completar um programa de formação, tendo o direito de exercer legalmente a profissão. Assume responsabilidade pelos cuidados durante a gravidez, parto e puerpério e fornece os cuidados necessários ao RN. Estes cuidados incluem medidas preventivas, a promoção do parto normal, a detenção de possíveis complicações materno fetais, o recurso a assistência médica e a realização de medidas de emergência.

Em Portugal, a formação especializada em ESMOG é precedida pela formação em Enfermagem em cuidados gerais, tendo por este motivo a designação de EEESMOG, entendido como um título sinónimo de parteira, à luz do enquadramento regulador da mobilidade dos profissionais no espaço europeu (OE, 2015).

A centralidade da ciência e da técnica nas sociedades contemporâneas determinam os domínios de influência dos processos de produção dos saberes e da abrangência do poder profissional. Desta forma, entramos no âmbito da caracterização das profissões a título de compor a problemática.

Carneiro (2008), recorda que os processos de estruturação de uma profissão obedece a ritmos históricos, formas culturais, jurídicas, configurações políticas e modelos de referência do Estado e dos grupos profissionais. Suscita-nos desta forma, a compreensão sócio histórica dos respetivos processos de formação, institucionalização e de identidade profissional do EEESMOG.

Nesta sequência, entendemos que o percurso social da ESMOG em Portugal é ainda remoto, apesar da atual conjuntura científica, técnica e humana e que bastou uma geração para que esse fenómeno ocorresse. Portanto, num espaço de trinta anos houve um retrocesso e um desacelerar na história da ESMOG, que nos custou o reconhecimento social das competências que regulam as nossas ações, que em tempos eram inquestionáveis. Por outro lado, esta limitação de saberes e este reprimir de funções, fez a Enfermagem sentir a necessidade de afirmar-se como disciplina e registar uma complexidade na evolução do seu exercício profissional, que como refere Araújo (2008), torna imperioso o seu reconhecimento no âmbito da saúde, na qualidade e eficácia dos cuidados que oferece. Para além da prestação de cuidados, os enfermeiros passaram também a atuar na gestão e na investigação em saúde, permitindo dominar a produção de saberes em enfermagem.

Perante esta conjuntura, falamos então de processo de profissionalização como fenómeno de construção social onde a profissão, formada por grupos heterogéneos internamente estratificados, exerce "poderes concretos e específicos que não sendo ilimitados, são historicamente variáveis, estruturalmente dispersos e necessitam de ser delineados em termos das instituições que os possibilitam" (Carapinheiro, 1993, p. 227). Estas Instituições, que neste caso são de saúde, são consideradas sistemas abertos, pois funcionam num contexto ambiental, que fornece 'outputs' sob a forma de bens e serviços e recebe 'inputs' sob a forma de matérias-primas (informação, mão de obra etc.).

Após este processo de estruturação da profissão, nos últimos 20 anos, a Enfermagem fortaleceu o seu agir profissional quer ao nível da formação de base superior e no que diz respeito à complexificação dos saberes com a especialização dos profissionais no exercício das suas intervenções. São disso exemplo, a publicação do REPE (D.L. nº 161/96 de 4 de Setembro de 1996), com referência aos princípios de atuação fundamentados numa cooperação e respeito mútuos, e a criação da Ordem dos Enfermeiros em 1998 (D.L. nº 104/98 de 21 de Abril), da qual emerge o Regulamento das CCEE e das Competências Específicas do EEESMOG, marcos significativos e vinculativos para a consolidação da autonomia responsável da profissão de Enfermagem e da ESMOG, como área específica.

Ainda que este agir profissional, envolvido por um perfil conceptual e legal, seja "pano de fundo" no desempenho do EEESMOG e das suas intervenções, parece faltar pressão sobre as estruturas de poder político e organizacional que garanta um espaço simbólico de intervenção com legitimidade social, cultural, científica e económica que conjugue o melhor interesse público e profissional (Araújo, 2008). Houve um investimento no processo de profissionalização em ESMOG mas o processo de construção social mostra-se ainda estruturalmente disperso.

Em termos de estrutura organizacional, uma instituição de saúde da qual faz parte a profissão de enfermagem, surge como a soma sinérgica da totalidade dos meios utilizados para dividir o trabalho entre tarefas distintas e para assegurar a coordenação e controlo da atividade a desenvolver, com vista à consecução de objetivos comuns, mediante uma hierarquia de autoridade, de responsabilidade e de divisão de trabalho (Ferreira, Neves, Abreu e Caetano, 1996). Contudo, o sucesso das políticas de saúde reside na compreensão e no respeito pela complementaridade das profissões (Oliveira, 2010), do todo que é a instituição de saúde.

Do ponto de vista social, Carapinheiro (1993), refere que uma profissão atende aos atributos ou características dos grupos profissionais, às etapas de evolução, à estrutura e formas de organização e à função social da mesma. As profissões distinguem-se então em grupos unidos por valores e ética de serviço à comunidade. Segundo a mesma autora, neste quadro teórico " a divisão do trabalho (...) é um conjunto de atividades, produto de um processo de diferenciação funcional, determinado pelo estado de técnica e pelas condições materiais de realização de tarefas" (Carapinheiro, 1993, p. 225), refletindo uma resposta às necessidades sociais essenciais, resultante de uma estrutura de conhecimento científico e prático aplicado na identificação e resolução de problemas. Portanto, em resposta às necessidades sociais identificadas e perante um grupo de profissionais com competências legalmente reconhecidas, o EEESMOG ganhou destaque nas equipas multidisciplinares e assumiu a autonomia assistencial como parte integrante do quadro de funções duma instituição de saúde (D.L. nº 104/98 de 21 de Abril de 1998).

Posto isto, compreende-se que o pilar organizativo sobre o qual assenta toda a estrutura e conteúdo dos cuidados de saúde numa organização de saúde é o trabalho em equipas transdisciplinares. Para tal, as atividades são desenvolvidas por profissionais com competências diferenciadas, mas complementares, onde existe um forte esforço de coordenação que leva a uma interdependência dos interesses individuais e dos interesses colectivos (Ferreira *et al*., 1996).

Contudo, uma profissão deve utilizar estratégias diversas que demarque uma posição de força (monopólio e exclusividade) sobre o mercado de trabalho, posição esta que permita maximizar vantagens económicas e sociais. Recorre-se aos mecanismos de socialização profissional, de transmissão das aprendizagens sociais e culturais que possibilitam a conquista e a perenização do estatuto da profissão, como veremos mais adiante.

Do ponto de vista das ciências humanas, o cuidar encerra no seu sentido lato, a transversalidade do conceito de saúde/doença. Neste sentido, atribuir funções simbólicas e ideológicas à função do EEESMOG, torna o processo de socialização da profissão mais complexo, apesar de que, um dos grandes contributos da perspetiva cultural e antropológica tem sido desvendar as dimensões mais tácitas do comportamento humano e demonstrar como estas dão significado e contribuem para dar forma à disciplina de Enfermagem.

Spink (1993), refere que legitimar o senso comum através da prática baseada na evidência e atribuir-lhe um caráter científico oferece garantia epistemológica, construção social e representação da realidade. Assim, para que a ESMOG seja encarada como um fenómeno social deve ser compreendido o seu conteúdo cognitivo e o seu contexto de produção, como se esclarece seguidamente.

2.2. DOMÍNIOS DA ESPECIALIZAÇÃO EM ESMOG E A SUA REPRESENTAÇÃO SOCIAL

A Enfermagem é paradigmaticamente a fusão harmoniosa dos saberes oriundos das ciências humanas e das ciências sociais, o que permite uma perspetiva transdisciplinar e um campo de atuação multidisciplinar.

Os Cuidados de excelência em ESMOG são um desafio importante para qualquer EEESMOG e o alcance desta excelência demonstra a arte de cuidar. No entanto, o exercício de cuidar uma mulher, nem sempre é tarefa fácil nem arbitrária, pois exige a coordenação de diversos fatores interpessoais, profissionais e institucionais. Portanto, relacionar o conceito de Cuidados de Enfermagem e Competência profissional em ESMOG leva-nos a pensar num processo dinâmico e interativo de mobilização de saberes, que culminam num agir profissional assertivo. Neste sentido, Oliveira (2010), salienta que o EEESMOG deve perceber e valorizar a sua importância e explorar convenientemente as suas virtualidades, agarrando novas oportunidades nas mais diversas áreas de intervenção para as quais possuiu competências.

O facto de ter ocorrido uma mudança no paradigma que conjuga a pessoa, a saúde, a doença, o ambiente e a prestação de cuidados para a visão de um todo dinâmico, indivisível, no qual as partes são essencialmente inter-relacionadas (Waldow, 1998, citado por Simões, 2008), tem influenciado a Enfermagem e o cuidar tem sido discutido nas suas múltiplas dimensões. Segundo esta visão, a mulher passou a ser considerada como ser total, que possui família, cultura, têm passado e futuro, crenças e valores que influenciam nas experiências de saúde e de doença. A representação da complexidade da Enfermagem é comum na maioria dos Modelos de

Enfermagem e cada modelo conceptual, apesar da sua especificidade, tem aspetos comuns. Como refere Pais Ribeiro (2008), citado por Morais (2012), combinam na visão holística e humanista a sua singularidade e autodeterminação na relação terapêutica entre o EEESMOG e a mulher cuidada.

De salientar que, não iremos abordar um modelo de enfermagem específico ou teórico de enfermagem, partilhando da opinião da MCEESMO (2015, p. 8), citado pela OE (2015), quando refere que "a filosofia de cuidados em ESMOG, na sua essência, é fortemente enraizada num modelo de assistência, em que o EEESMOG trabalha em parceria com a mulher, colocando-a no lugar central durante o ciclo reprodutivo". Garante ainda, uma continuidade de cuidados na qual melhora e protege o processo normal de parir e nascer.

Nesta conjuntura, a evolução da Enfermagem como disciplina ganha contornos, uma vez que o seu foco de atuação é o Cuidar multidimensional, característica inigualável desta profissão e, afirmar-se como área de uma disciplina com conhecimento autónomo, num campo de intervenção próprio é o objetivo da ESMOG. Esta, toma por objeto de estudo, não a doença em si, mas a resposta humana aos problemas de saúde e aos processos de vida, assim como, as transições enfrentadas pela mulher ao longo do ciclo de vida reprodutivo (Regulamento n.º 127/2011).

A transição, considerada como processo relacionado com a vida e a saúde (Kralik, Visentin e Loon (2006), citado por Magalhães (2011), pode ser desencadeada por eventos ou pontos críticos, aqui entendida como a mudança de papel provocado pelo nascimento, e requer que a parturiente/acompanhante seja capaz de incorporar as mudanças na sua vida, alterando o seu comportamento e redefinindo a sua identidade. À luz da Teoria das Transições de Meleis *et al*. (2000), (Anexo I), o EEESMOG é o principal cuidador da parturiente/acompanhante, assistindo às mudanças e exigências que as transições provocam, ajudando-os na preparação para as transições iminentes e facilitando o processo de aprendizagem de competências, uma vez que a parentalidade é um processo individual, conjugal e social, Ramos (2005), citado por Magalhães (2011).

Chick e Meleis (1986, p. 239), definiram transição como "a passagem de uma fase da vida, condição, ou status para outra (...) refere-se tanto ao processo como aos resultados da complexa interacção entre pessoa e ambiente. Pode envolver mais do que uma pessoa e está inserido num determinado contexto e situação. As características da transição incluem o processo, a percepção da alteração e os padrões de resposta". Neste sentido, a parturiente/acompanhante deve ser perspetivada em constante interação com o ambiente, com necessidades específicas e com capacidade de se adaptar às mudanças, mas devido ao risco de doença ou vulnerabilidade, experimenta ou está em risco de experimentar um desequilíbrio (Meleis, 2005).

Mais acrescenta Meleis (2007), que o conceito de transição acomoda simultaneamente continuidade e descontinuidade dos processos de vida, definindo-se por períodos de entropia entre estados de equilíbrio. Posto isto, manter a saúde, requer consciencialização, empoderamento, controlo e mestria na vida e, a ausência desse equilíbrio, coloca a parturiente/acompanhante na eminência de uma transição (Meleis, 2007).

Meleis *et al*. (2000), desenvolveram uma teoria de médio alcance que descreve a natureza (tipo, padrões e propriedades), as condições facilitadoras e dificultadoras e os padrões de resposta (indicadores de processo e resultado) comuns aos processos de transição que guiam as intervenções de enfermagem. Esta teoria permite ao EEESMOG pôr em prática estratégias de prevenção, promoção e intervenção face à transição que a parturiente/acompanhante vivencia.

Na perspetiva de Galhardo (2004), possuir uma competência ou uma especialização dificilmente substituível, coloca a ESMOG numa posição favorável à negociação e detentora de um certo poder. Ainda no âmbito da problemática, partilhamos da opinião de Galhardo (2004), quando refere que os cuidados prestados pelo EEESMOG num bloco de partos, contexto de ação do estudo, são muito mais visíveis que em qualquer outro espaço de trabalho, devido às características específicas das intervenções que desenvolvem, exponenciando a autonomia devidamente legislada.

Nunes (2003), problematiza o tipo de saberes produzidos na prática e a sua forma de produção, uma vez que, o conhecimento transpõe da epistemologia clássica à incorporação do social, com uma consequente relativização da objetividade e o senso comum como conhecimento legítimo e motor de transformações sociais (Spink, 1993). Por outro lado, Fuller (1988), citado por Spink (1993), refere que a aceitação social envolve a concessão de garantia epistemológica e esta por sua vez é uma forma encoberta de distribuir poder. Nesta ordem de ideias, a componente prática de ESMOG é, concomitantemente, campo socialmente estruturado que só pode ser compreendido quando referido às condições da sua produção e aos núcleos estruturantes da realidade social, tendo em vista o papel do EEESMOG na criação dessa realidade (Spink, 1993).

Por outro lado, Lopes (2001), citado por Araújo (2008), reflete que o investimento dos profissionais em formação, na construção de saberes científicos, na criação de códigos deontológicos, apenas configuram estratégias de profissionalismo, adoptando atitudes relativas ao trabalho e à identidade profissional, mas estas não geram reconhecimento social como profissão, uma vez que não asseguram por si só a sua autonomia funcional.

Nesta perspetiva, devemos pensar nas questões que bloqueiam a dinâmica da representação social da ESMOG e desenvolver, estimular, confortar e compensar, como refere Collière (2003), a possibilidade de existir, traduzido no verdadeiro valor do cuidado dirigido à mulher durante todo o ciclo de vida reprodutivo. De facto, como salienta Amendoeira (2006), o Enfermeiro, no qual se inclui o EEESMOG, deve articular as dimensões - Contexto, Saberes e Atores, que interagem no processo de cuidar, para dele emergir os conceitos operacionais do EEESMOG, numa combinação entre o *Resultado* - os ganhos em saúde sensíveis à ação do EESMOG, *Do que se Fez* - a ação autónoma, *A Cada Pessoa* - o sujeito alvo do processo de cuidados, que lhes confere poder e um grau de significância na sociedade.

Ainda assim, a sociedade exige elevado nível de competência e qualidade nos cuidados de saúde prestados, mas não reconhece nem atribui um estatuto (entendido como a posição de um individuo no conjunto de todos os indivíduos (Sêga, 2000), e poder social ao EEESMOG que imprima representação social em ESMOG.

Alexandre (2004), salienta que não é todo o conhecimento de uma disciplina que pode ser considerado representação social, mas apenas aquele que faz parte da vida quotidiana das pessoas, através do senso comum, que é elaborado socialmente e que funciona no sentido de interpretar, pensar e agir sobre a realidade. Nesta dinâmica, faz sentido a vertente técnica e prática da ESMOG, assim como, a prática baseada na evidência com a qual se produz conhecimento simbólico e prático capaz de conferir cientificidade.

O Conselho Diretivo da Ordem dos Enfermeiros (2010), refere que os pilares fundamentais para o processo da autonomia da ESMOG são o desenvolvimento da educação e da investigação. Mais acrescenta a OE (2015), que o EEESMOG presta assistência à mulher em idade fértil, atuando no ambiente em que vive e se desenvolve, sendo que estão autorizados e legitimados a exercer a sua atividade autonomamente. Na área em estudo, o EEESMOG cuida da parturiente/acompanhante durante o TP (processo que tem como finalidade expulsar o feto, placenta e as membranas para o exterior do útero pelo canal de parto, através de um conjunto de fenómenos fisiológicos (Bobak, Lowdermilk e Jensen, 1999), em ambiente seguro, no sentido de otimizar a saúde da parturiente/puérpera e RN na adaptação à vida extra uterina.

Neste contexto, a representação social apresenta-se como uma forma de interpretar e pensar a realidade quotidiana, com o intuito de promover o conhecimento e fixar a sua posição em relação às situações do contexto clínico, eventos adversos e relações que lhes estão associadas. Por outras palavras, a representação social é construída por um conhecimento prático, que dá sentido aos eventos que são normais e advêm da evidência da nossa realidade (Sêga, 2000). Contudo, o mesmo autor acrescenta que esta realidade surge vinculada pelo contexto concreto no qual se situa o EEESMOG, pela comunicação que se estabelece entre eles, pelo quadro de referências que fornece a sua bagagem cultural, pelos códigos, símbolos, valores e ideologias ligados à posição social específica da ESMOG.

Carapinheiro (1993), salienta que o corpo formal e abstrato de conhecimentos, em torno do qual se ancora a ESMOG, juntamente com as instituições que asseguram a sua transmissão e proteção, estão na base do estatuto e poder da profissão. Verifiquemos então a atitude profissional do EEESMOG que deve gerar atitude social, a sua representação, no sentido de conjugar simbióticamente o campo de saberes, o campo de atuação e o campo social em ESMOG. Por outro lado, Collière (1999) citado por Araújo (2008) refere que, a vertente socioeconómica influencia a orientação da prática de cuidados e que os cuidados em ESMOG, por sua vez, influenciam todas as dimensões do contexto de saúde, deixando um construto capaz de definir uma imagem social. Partimos então do pressuposto de que embora o desenvolvimento crítico do EEESMOG não seja ainda suficiente para a transformação da sociedade, é absolutamente necessário que ele ocorra, uma vez que o envolvimento em processo de mudança demanda um mínimo de percepção do poder individual que sustente um processo produtivo de convivência nos espaços coletivos (Carvalho, 2004).

Nesta área da saúde, "as identidades sociais e profissionais típicas não são nem as expressões psicológicas de personalidades individuais nem os produtos de estruturas ou de políticas económicas impostas (...), elas são construções sociais que implicam a interação entre

as trajetórias individuais e os sistemas de emprego, de trabalho e de formação" (Dubar, 1991), citado por Araújo, 2008, p. 45). Apesar disso, as tecnologias utilizadas, o modo de hierarquização social que criam, as formas institucionais que definem, a sua organização ou pelo alcance social do ato de cuidar em ESMOG tem uma influência social inquestionável mesmo que esta não seja assumida de forma imediata num contexto desvirtuado de conteúdo e conhecimento (Araújo, 2008). Neste sentido, o mesmo autor refere que a recomposição de identidades sócio profissionais, o valor de uma profissão como ESMOG não pode basear-se noutro aspeto que não seja a valorização do seu contributo específico e insubstituível para a saúde da população.

Do ponto de vista da estrutura social, é através da sociedade, da interação e das relações pessoais que a ESMOG encontra expressão da sua subjetividade e insubstitualidade. Segundo Alexandre (2004), é no partilhar da intersubjetividade que o EEESMOG adquire a certeza da realidade vivida e percebe a diferença entre a sua realidade e a dos outros, e a formação da representação social a partir da realidade quotidiana, constitui uma grande força para que estas possam ser tratadas e reconhecidas como conhecimento em ESMOG pela sociedade.

Posto isto, o conceito de representação social é apresentado por Jodelet (1984), citado por Alexandre (2004), como sendo uma modalidade de conhecimento particular que tem por função a compreensão do contexto social, material e ideológico em que vivemos, uma vez que sendo socialmente elaborado e partilhado, contribui para a construção da realidade das competências do EEESMOG. A percepção da parturiente/acompanhante sobre determinada situação clínica requer uma representação de conjunto que segue uma linha de influência social, onde esta é entendida como um conflito cognitivo que se origina entre informações adquiridas diretamente por ela e aquelas transmitidas pelo seu ambiente social (Moscovici, 1994, citado por Alexandre, 2004). Moscovici acrescenta ainda que, a representação social é uma preparação para a ação, tanto por ser conduzido pelo comportamento do EEESMOG como por modificar e reconstituir os elementos do meio ambiente que o comportamento deve ter lugar. Noutra perspetiva, Dorse (1990), citado por Sales (2008), salienta que a representação social constitui-se como a organizadora das relações simbólicas entre os diferentes atores sociais e a mesma incorpora autonomia de criação individual e coletiva.

Em continuidade desta perspetiva, Jodelet (1989), citado por Spink (1993, p. 304), acrescenta que "as representações sociais devem ser estudadas articulando elementos afetivos, mentais, sociais, integrando a cognição, a linguagem e a comunicação às relações sociais e à realidade material, social e ideativa sobre a qual elas intervêm." Ora, a ESMOG e o seu campo de ação em tudo se assemelha às características atrás mencionadas, no domínio das relações interpessoais, habilidades comunicacionais, cognitivas e técnicas. Assim, numa Instituição de Saúde a expressão de identidade do EEESMOG engloba esta perspetiva de interdisciplinariedade, que é influenciada por diversos atores e fatores não passivos, em espaços partilhados e com um objeto comum de intervenção.

Por outro lado, pelo facto da parturiente/acompanhante fazer a gestão do seu processo de saúde dá ao EEESMOG poder de intervenção, pelo processo de cuidados especializado, na promoção do reconhecimento das suas competências intelectuais, científicas, técnicas e humanas

para que possa causar monopólio e exclusividade em ESMOG (Araújo, 2008). Estas competências em ESMOG que justifica os novos contextos de saúde/doença, a evolução tecnológica e a complexidade do cuidar, resulta da reflexão nos contextos de ação da prática, pelos avanços recorrentes da evidência e traduzem-se na qualidade dos cuidados de saúde prestados (Araújo, 2008).

Entendemos pois que, a representação social de conjunto requer uma transmissão de conteúdos em ESMOG de forma uniforme, através da produção de comportamentos e da comunicação do EEESMOG igualmente uniforme. Curioso será identificar que o trabalho de parto de baixo de risco é realizado em plenitude pelo EEESMOG e efetivamente não se reflete numa condição socialmente entendida como autónoma do mesmo havendo ainda uma determinante de dependência e não de complementaridade profissional.

Face a isto, procuramos entender que domínios caracterizavam a especialização em ESMOG e como estes devem produzir representação social, através do Empoderamento Social do EEESMOG, como perspetivamos no subcapítulo seguinte.

2.3. EMPODERAMENTO SOCIAL DO EEESMOG

O Empoderamento tem sido utilizado em vários campos profissionais e em diversas disciplinas, com diferentes alcances e definições. No sentido mais geral, refere-se à habilidade das pessoas em ganhar conhecimento e controlo sobre forças pessoais, sociais, económicas e políticas para agir na direção da melhoria da sua situação de vida. Pode igualmente ser descrito como o poder de promover a afirmação ou a influência (Cunha, 1992) e pode ser entendido na forma individual, organizacional e comunitária.

Neste campo, vamos entendê-lo na forma individual/grupo profissional, nomeadamente na forma de EEESMOG/grupo profissional em ESMOG e na forma organizacional (instituição de saúde), como coadjuvante do anterior. E a direção utilizada recai sobre o grupo profissional em ESMOG que ganha conhecimentos e controlo sobre as suas forças pessoais, sociais, económicas e políticas para agir na direção da melhoria da sua situação profissional e social daí decorrente. Pretende-se pois que, o comportamento intrínseco do EEESMOG (Empoderamento) traduza uma expressão/conduta que modele uma representação social em ESMOG através do seu empoderamento social, como teremos oportunidade de desenvolver.

Esta abordagem exige uma mudança, por um lado da cultura dos sistemas de saúde, e por outro, na atitude dos profissionais, principalmente no desenvolvimento das suas capacidades e competências e na partilha dessas características, no sentido de promover o reconhecimento junto da parturiente/acompanhante. Entre outros, os mecanismos burocráticos, medicalizados e as dinâmicas institucionalizadas dificultam o desenvolvimento das competências do EEESMOG e o reconhecimento social, justificando o interesse em refletir acerca desta temática, no desenvolvimento deste percurso formativo.

A abordagem do conceito de empoderamento data de finais da década de 1970, nos EUA, mas a sua implementação e aceitação como paradigma surge a partir do final da década de 1980. Exerce o seu domínio no serviço social e noutras profissões de cariz social e humano (Perkins, Zimmerman, 1995).

Exatamente pelo facto do conceito revelar-se polissémico, multidisciplinar e multidimensional que o adotamos na área da saúde e desta feita em prol do desenvolvimento pessoal e profissional do EEESMOG. É certamente um termo multiforme: é usado simultaneamente para descrever teoria, enquadramento teórico, ideologia, paradigma, filosofia, processo, resultado, potencial, objetivo, ou mesmo um sentimento. Nesta lógica, vem sendo reconhecida por muitos a importância e a necessidade de se desenvolver mais estudos sobre este conceito. Em particular, uma das áreas que sentimos mais descurada é o entendimento que o EEESMOG faz do empoderamento e as práticas que efetivamente se desenham no terreno da ação, apresentando-se o empoderamento mais como *slogan* legitimador das ações no plano teórico e menos como uma prática de intervenção com identidade própria (Pinto, 2011).

Definir empoderamento constitui um desafio que nos leva a refletir sobre a consolidação das práticas especializadas em ESMOG, alicerçadas no seu poder profissional. É evidente que há muitos fatores historicamente determinantes que dificultam a visibilidade do EEESMOG, como a formação tradicional que privilegiou uma cultura biomédica e por consequência a subordinação, e o poder decisório que a ESMOG tem assumido nas instituições de saúde, estar centrado mais na operacionalização do que na formulação de políticas.

A questão em foco, relativa à conceptualização e aplicação do empoderamento em ESMOG prende-se com a relação entre teoria e prática, ou seja, entre o conhecimento científico e a ação na prática e a produção de resultados sensíveis ao seu empoderamento social. Teoria e prática são indissociáveis, num contínuo movimento dialético e analisar as práticas profissionais constitui em si mesmo uma estratégia de produção de conhecimentos (Almeida, 2001). Nas palavras de Freire (1977), qualquer ação de transformação da realidade que não se apoie num conhecimento do real está condenada ao fracasso. Qualquer esforço de compreensão da realidade que não implique uma aceitação dessa mesma realidade, é ilusório.

Perkins e Zimmerman (1995, p.1) definiram empoderamento como "um constructo que liga forças e competências individuais, sistemas naturais de ajuda e comportamentos proactivos com políticas e mudanças sociais". Trata-se pois da constituição do grupo profissional ESMOG mediante um processo no qual o EEESMOG obtém o controle sobre a sua atividade clínica, participa democraticamente no quotidiano profissional e compreende criticamente o seu ambiente. Portanto, empoderar é o processo pelo qual o EEESMOG angaria recursos que lhe permite ter voz, visibilidade, influência e capacidade de ação e decisão. Como o acesso a esses recursos é normalmente automático para a sua obtenção é necessário ações estratégicas (Horochovski e Meirelles, 2007).

Não será o empoderamento como processo social o caminho a percorrer na conquista, perenização da profissão e afirmação das competências do EEESMOG? Até que ponto o EEESMOG pode realizar o ideal de empoderamento com vista à representação social em

ESMOG? O que faz o EEESMOG na sua prática diária no sentido desse tipo de mudança social? Será que temos pensado realmente nas implicações da adoção do empoderamento na prática do EEESMOG? Como refere Ann Hartman (1993), citado por Pinto (2011), pode ser que o empoderamento esteja mais nos discursos do EEESMOG do que na sua prática real. Porque os obstáculos à sua concretização são imensos e aos mais variados níveis.

Moreira (2007), citado por Araújo (2008, p. 49), refere que "... também em Portugal a profissão enfrenta uma série de desafios de comunicação institucional, gestão de imagem profissional (em concorrência com outras profissões de saúde) e a necessidade de influenciar a opinião pública". Mais acrescentam Buresh e Gordon (2004), que a ESMOG não pode querer ser considerada como profissão relevante na saúde se não tornar visível e não exprimir a sua visão e opinião em grandes questões dos cuidados de saúde contemporâneos. É nesta conjuntura que se enquadra o empoderamento em ESMOG, como profissão integrante nas políticas de saúde, apresentando-se com um perfil multiprofissional, constituindo um sistema interdisciplinar que tem o poder como fio condutor (Salvador, Alves, Martins, Santos e Tourinho, 2013). Posto isto, entende-se que as relações de poder não são unidireccionais nem se detêm num único momento do tempo (Nóbrega - Therrien, 2004, citado por Salvador *et al.*, 2013). Pelo contrário, as relações de poder em ESMOG são complexas e ultrapassam as práticas profissionais e a subjetividade dos sujeitos envolvidos.

Buresh e Gordon (2004), salientam que um dilema estratégico para a ESMOG é a falta de compreensão que o público tem do seu trabalho. Paradoxalmente, o reconhecimento conceptual é evidente na relação do EEESMOG com as instituições de saúde, pelas suas competências académicas e pela atribuição de autonomia funcional, mas não é linear no que respeita aos pares, à equipa multidisciplinar e à parturiente/acompanhante. Neste sentido, as mesmas autoras defendem que a resposta a este mutismo social termina na emergente necessidade de sistemas de informação e comunicação pública, como prevê o Regulamento de Competências Especificas do EEESMOG (OE, 2011), sobre o impacto das suas intervenções e os obstáculos internos que os silencia.

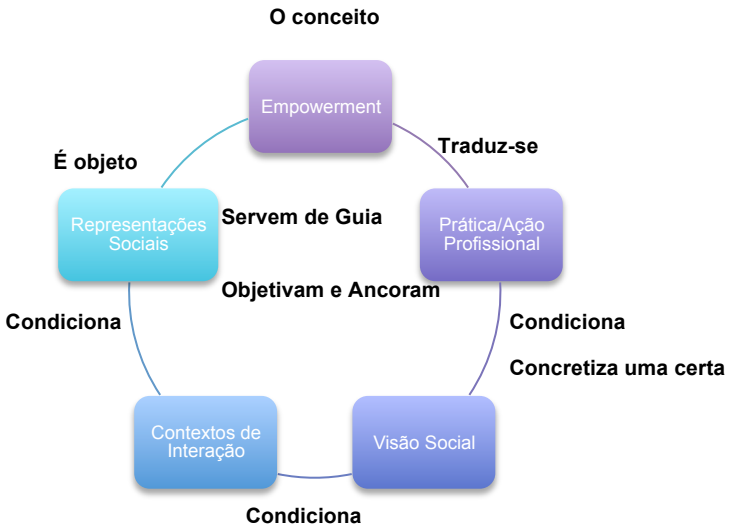
Mais acrescenta Frederico (2006), citado por Pereira, Fernandes, Tavares e Fernandes (2011), que Empoderamento é (...) um processo de criação e utilização de recursos (...) que se traduz num acréscimo de poder psicológico, sociocultural, político e económico, que permite aumentar a eficácia do exercício profissional e a sua representatividade a nível social.

Neste contexto, deve entender-se o empoderamento como o potencial de exercer influência e como um fenómeno transformacional, que promove o crescimento individual e grupal pelo encorajamento da reciprocidade, do estímulo ao pensamento criativo, da expansão do conhecimento e do favorecimento da consciencialização (Cruz, Pimenta, Pedrosa, Lima e Gaidzinski (2009), citado por Salvador *et al*., (2013). Trajetórias estas que, embora individuais, espelham o grupo profissional, ou seja, com práticas clínicas que se querem homogéneas e impactantes. É neste sentido, de ação de transformação coletiva, em que se vislumbram desejos intencionais e coletivos de influenciar a opinião pública, que se pretende compreender o empoderamento social do EEESMOG.

Por outro lado, o papel e a natureza das organizações de saúde são essenciais para perceber as práticas efetivas dos profissionais, e particularmente para perceber as representações e práticas de empoderamento eventualmente aplicadas (Beresford, Croft, 1993), citado por Pinto (2011). Também a equação pessoal do EEESMOG revela-se de grande importância na construção das relações EEESMOG - parturiente/acompanhante e na operacionalização dos procedimentos técnicos da organização (Hasenfeld, 2000), citado por Pinto (2011). Os sistemas de crenças pessoais do EEESMOG e as suas racionalizações morais tendem a ser partilhados entre as equipas da instituição e entre profissionais da mesma formação através da partilha de formação, experiências, exigências de trabalho e processos de comunicação. Por meio desta comunidade de normas, estes sistemas morais acabam por ser institucionalizados nas práticas organizacionais, mas podem permanecer invisíveis para os seus "produtores" e agentes (Hasenfeld, 2000), citado por Pinto (2011).

Como podemos observar na Figura n.º1, o empoderamento é objeto de representações e é aplicado por meio de determinadas práticas profissionais (Hasenfeld, 2000, citado por Pinto, 2011). Estas representações e práticas condicionam-se mutuamente, servindo as representações de empoderamento como guia e justificação das ações, e por sua vez, as práticas profissionais ancoram e objetivam as representações do conceito.

Figura n.º 1 - Empowerment: representações e práticas - modelo de análise



Adaptado (Hasenfeld, 2000, citado por Pinto, 2011)

Quer as representações, quer as práticas do empoderamento, na nossa perspetiva, são condicionadas pelos contextos da intervenção profissional e pelas representações socais da própria profissão. O caminho evolutivo que alimentou o conceito de empoderamento tem sido um caminho que se pretende de emancipação, de libertação e autonomização do EEESMOG, em termos pessoais e coletivos, relativamente a estruturas, conjunturas e práticas sociais, culturais, económicas e políticas que são tidas como injustas, opressivas e discriminatórias.

Segundo Sêga (2000), as fases da evolução de uma disciplina nomeadamente em ESMOG são: as atitudes sociais, as cognições sociais e as representações sociais. Neste sentido, há que ocorrer um domínio de influência (atitude social), através da centralidade da ciência e da técnica no poder profissional (cognição social) e desta forma criar uma consciência coletiva, através de normas de conduta, que seja aceite e praticado pela generalidade dos EEESMOG (representação social). Afirmar a prática de ESMOG como ação nesse contexto, traduz-se na compreensão do poder como mecanismo de reconstrução, de resgate e de reestruturação que abrange a consciencialização do EEESMOG na perspetiva da sua emancipação como sujeito social e a defesa da ESMOG como categoria que tem responsabilidades com os projetos institucionais e com a mulher em todo o seu ciclo de vida reprodutivo (Regulamento n.º 127/2011).

O conhecimento, visto como meio de obter competência no agir e assegurar o poder, proporciona segurança na tomada de decisão, garante competências e habilidades e confere domínio para agir de forma cientificamente consensual. Neste sentido, Salvador *et al*. (2013), garante que é necessário que se afirme o poder clínico do EEESMOG. Este é compreendido como a perceção do enfermeiro de ser intelectual, física e emocionalmente capaz e preparado para interpretar respostas humanas, planear, implementar e avaliar intervenções de enfermagem de forma eficaz, proporcionando mais consciencialização do seu poder clínico, mais intencionalidade e envolvimento para decidir o que fazer, entendendo-se assim o significado de empoderamento individual.

Portanto, ao nível do empoderamento individual, na qualidade do EEESMOG, assiste-se à formulação de uma imagem "*empoderada*" (com poder) como sendo aquele que é comedido, independente e autoconfiante, capaz de comportar-se de uma determinada maneira e de influenciar o seu meio e atuar de acordo com abstratos princípios de justiça e de equilíbrio (Riger,1993, citado por Carvalho, 2004). Deste empoderamento deriva estratégias de promoção que têm como objetivo fortalecer a auto estima e a capacidade de adaptação ao meio e o desenvolvimento de mecanismos de auto ajuda e autoconfiança que pode favorecer a manutenção do *Status quo*. Isso permite que se afirme a importância da autonomia e tomada de decisão do EEESMOG no processo de cuidados (Carvalho, 2004), assim como implica, muitas vezes, a redistribuição do poder e a resistência daqueles que o perdem.

O contexto de exercício profissional traduz-se em práticas onde existe um relacionamento face a face, conjugando as particularidades de cada parturiente/acompanhante e o cuidado sistémico inserido num quotidiano complexo. A ESMOG é entendida como uma prática na ação intencionalmente construída e assente em conhecimentos científicos. O EEESMOG cria e recria representações pelos contextos de intervenção profissional e pela representação social da própria profissão neste que, analogamente aos conceitos de empoderamento e representação social, consideramos Empoderamento Social do EEESMOG.

Não existe uma definição específica para Empoderamento Social, mas deriva da associação de vários factores que compõem a esfera social e a demarcam do ponto de vista do Empoderamento numa lógica correlativa do empoderamento como processo social de reconhecimento, promoção e aumento de capacidade de identificação de necessidades e

satisfação das mesmas, resolução de problemas e mobilização de recursos necessários no sentido de controlarem a sua atividade clínica (Gibson, 1991).

A meta da prática de empoderamento social procura tornar o EEESMOG, um agente causal capaz de exercer influência no seu meio, como recurso de conhecimento, com saber-poder e por este motivo difunda o conceito de profissional de referência a nível social. É imperativo entender as motivações do EEESMOG para afirmar o empoderamento das suas práticas e compreender o seu poder clínico. No contexto da prática clínica parece haver uma incompatibilidade com as reflexões relativas ao agir, o que impossibilita a reflexão da finalidade dos atos, elemento ímpar ao empoderamento da prática (Pinto, 2011).

Zimmerman (1990), acrescenta que o empoderamento envolve um entendimento crítico do ambiente social por se apresentar dinâmico e contextualmente orientado. Assim, um recurso do empoderamento social será a relação de poder social do EEESMOG. Sendo um conceito inexistente em literatura, procuramos definir empoderamento social como o recurso do poder que estabelece o grau de empoderamento atingido ou poder social associado.

Friedman (1996) e Antunes (2002), citado por Horochovski e Meirelles (2007), referem-se ao poder social (empoderamento social) como o *status* do EEESMOG no contexto da prática onde encontra necessária a tomada de decisão que coaduna com as ações dos próprios, nomeadamente a capacidade de verbalização das suas competências, a intensidade com que a sua voz é ouvida e legitimada (relação direta com a visibilidade que adquirem) e a coesão do grupo profissional ESMOG. A representação social na forma de ação (empoderamento social) é realizada pelo EEESMOG nos processos de cognição da parturiente/acompanhante, o que permite influenciar, estimular e seduzir, induzindo a vontade, a motivação e o comportamento de quem a perceciona. (Moreira, 2010)

A busca da valorização das práticas do EEESMOG requer que os profissionais invistam na busca de conhecimentos que subsidiem a prestação de cuidados qualificada e que, além disso, estejam dispostos a discutir o significado desses cuidados de acordo com a realidade dos contextos de ação, com a PBE.

Seguidamente, apresentaremos a metodologia de reflexão sobre o contexto de ação, utilizando a RSL, como técnica de investigação em Enfermagem.

3. METODOLOGIA DE PESQUISA

A RSL emerge perspetivando fundamentar a singularidade das situações de cuidar e dar resposta aos problemas da prática de cuidados. Podemos ainda considerar como sendo uma forma de pesquisa que utiliza como fonte de dados a literatura sobre determinado tema. Ajuda a esclarecer como o tema foi examinado e que evidência de pesquisa foi adquirida (Evans e Pearson, 2001).

Este tipo de investigação disponibiliza um resumo de evidências relacionadas a uma estratégia de intervenção específica, mediante a aplicação de métodos explícitos e sistematizados de busca, apreciação crítica e síntese de informação selecionada (Sampaio e Mancini, 2007). Procura uma síntese rigorosa de todas as pesquisas relacionadas com uma questão específica, que pode ser sobre causa, diagnóstico, prognóstico de um problema de saúde, mas frequentemente envolve a eficácia de uma intervenção para a resolução deste (Galvão, Sawada e Trevizan, 2004). Esta abordagem requer uma sequência de etapas cuja metodologia é claramente explicitada, com técnicas padronizadas e passíveis de reprodução (Lopes e Fracolli, 2008), sendo uma das metodologias mais seguidas, aplicadas à evidência em enfermagem.

Seguiu-se a temática do Empoderamento Social do EEESMOG, como forma de construir uma consciência coletiva de representatividade social em ESMOG. Como ponto de partida para a revisão sistemática da literatura foi formulada a seguinte pergunta de pesquisa:

"No Cuidar da Mulher em trabalho de parto, que competências (I) o EEESMOG (P) demonstra que desencadeie Empoderamento Social (O)?" (formato PI[C]O).

Para a formulação da pergunta foram definidos os critérios apresentados no quadro n.º1:

Quadro n.º 1 – Critérios para a formulação da questão de investigação

				Palavras Chave
P	**Participantes**	**Quem foi estudado?**	**EEESMOG**	**Midwives** **Labour** **Social** **Empowerment**
I	**Intervenções**	**O que foi feito?**	**Competências**	
C	**Comparações**	**Podem existir ou não**		
O	**Outcomes**	**Resultados/Efeitos/consequências**	**Empoderamento social na prática clínica**	

A utilidade de qualquer RSL depende largamente da qualidade dos estudos incluídos. A busca de estudos realizada de forma vasta, sistematizada, com o mínimo de viés, consiste num dos aspectos que diferencia a revisão tradicional da revisão sistemática. Assim, a avaliação crítica consiste na fase onde todos os estudos selecionados são avaliados com rigor metodológico, com

o propósito de averiguar se os métodos e resultados das pesquisas são suficientemente válidos para serem considerados (Galvão *et al*, 2004).

Através da plataforma eletrónica EBSCO, foram utilizadas as seguintes bases de dados: a CINAHL Plus with Full Text, MEDLINE with Full Text e MedicLatina with full Text. A 2015.05.20, foram pesquisados artigos científicos, publicados entre 2009.01.01 e 2015.05.31 em texto integral, usando as seguintes palavras-chave, na sequência apresentada: **Midwives** AND **Labour** AND **Social** AND **Empowerment.** À semelhança da inexistência de definição de empoderamento social na literatura o mesmo verificou-se na conjugação na plataforma DeCS, havendo que utilizar as palavras chave em separado, conforme descrito anteriormente. As palavras chave foram verificados na base internacional MeSH Browser (Anexo II) e conjugados na plataforma DeCS (Anexo III), que de acordo com a concetualização foram hierarquizadas e para os quais se obteve um total de **98** artigos. Após a leitura do título e do resumo dos artigos pesquisados obtiveram-se **15** artigos (Anexo IV). Estes foram lidos na íntegra (Anexo VI) e considerando os critérios de inclusão/exclusão (quadro n.º 2), selecionaram-se **5** (Anexo V), que constituem um dos pilares para a elaboração da análise reflexiva e respetivas conclusões.

Quadro n.º 2 – Critérios de Inclusão/Exclusão dos Estudos

Critérios de Inclusão	Critérios de Exclusão
- Estudos onde a população alvo fosse grávidas, parturientes, puérperas ou EEESMOG; - Estudos desenvolvidos em contexto de ESMOG, com especial enfoque no período de Trabalho de Parto em meio hospitalar; - Estudos onde a abordagem de cuidados prestados por EEESMOG fosse apresentada, assim como, expetativas/perceção sobre o seu papel, competências e autonomia; - Estudos onde a abordagem do empoderamento na vertente da mulher cuidada e na vertente do grupo profissional EEESMOG fosse apresentada.	- Estudos em que a população alvo não fosse grávidas, parturientes, puérperas ou EEESMOG; - Estudos com data anterior 2009; - Estudos sem correlação com a temática em estudo. - Estudos com enfoque apenas perspetiva histórica dos cuidados em ESMOG; - Estudos direcionados a dispositivos médicos e a plataformas informáticas; - Estudos em que a temática focava situações de abortamento; - Estudos com enfoque na satisfação/motivação no trabalho em termos de políticas de gestão da instituição de saúde; - Estudos em contexto exclusivo de cuidados de saúde primários e cuidados de ESMOG prestados em domicílio.

Os cinco artigos selecionados foram classificados por uma escala de 7 níveis de evidência, segundo Melnyk e Fineout-Overholt (2005), onde quatro encontram-se no nível seis de evidência e um no nível um de evidência.

Seguidamente apresentamos as principais conclusões dos estudos filtrados na RSL (Quadro n.º 3) e procederemos no subcapítulo seguinte à análise reflexiva dos contributos dos mesmos para a prática em ESMOG. Utilizaremos a designação de parteira, entendida como um título sinónimo de EEESMOG à luz do enquadramento regulador da mobilidade dos profissionais no espaço europeu (OE, 2015), na apresentação dos textos pesquisados, pensando ser o mais fiel possível à tradução.

Quadro n.º 3 – Síntese das Principais Conclusões dos Estudos filtrados na RSL

"Women's Perceptions Of A Midwife's Role: An Initial Investigation" Cooper e Lavander (2013) Objetivo: Explorar a percepção das mulheres sobre o papel da parteira	
População **9 Mulheres** **NE VI: Estudo Qualitativo**	- A percepção dos cuidados difere se o acompanhamento foi feito pela parteira ou pelo médico; - A parteira promove o Empoderamento da mulher, dando suporte, garantia e coragem, que as capacita para a gravidez, TP e Puerpério, permitindo um parto normal e uma vivência positiva; - A família/amigos, meios de comunicação e experiências anteriores influenciam as expectativas do parto e do papel da parteira, onde realçam a componente relacional; - O papel da parteira só aparece ressaltado se for produzido essencialmente na ausência do médico, isento de influências do seu papel/estatuto, não havendo referência da sua presença.
"Mother's expectations of midwives care during labour in a public hospital in Gauteng" Sengane (2013) Objetivo: Determinar as expectativas das mulheres perante os cuidados prestados pela parteira durante o TP	
Sem indicação da amostra **NE VI: Estudo Qualitativo**	No âmbito interrelacional as mulheres identificaram equidade, corresponsabilidade, empoderamento, decisão informada, continuidade de cuidados e esperam que a parteira: - Realize o acolhimento com enfoque nas necessidades, no estado emocional, problemas sociais e conhecimentos e só depois a avaliação física; - Promova medidas de conforto, toque terapêutico, hidratação oral e higiene, incentive a presença do pai/acompanhante significativo, a relação da tríade familiar e do papel parental; - No 2º estadio de TP promova uma posição de conforto, técnica da episiotomia otimizada, higiene e conforto, hidratação oral e avaliação do bem estar materno fetal eficaz; - Mostre sensibilidade, simpatia, empatia, habilidades comunicacionais (informem de forma clara sobre os procedimentos, as suas ações, resultados, termos utilizados e felicitem pelo nascimento) e realize formação contínua em competências relacionais e comunicacionais.
"Women's experiences of care during labour in a midwifery-led unit in the Republic of Ireland" McNelis (2013) Objetivo: Explorar as experiências das mulheres em cuidados prestados pela parteira	
População **8 Mulheres** **NE VI: Estudo Qualitativo**	- Identificou-se 2 categorias de experiência: o ambiente calmo/terapêutico, através do respeito, privacidade, cuidados personalizados, suporte emocional e o empoderamento da mulher, com transmissão de segurança, proteção e gestão do processo de TP; - Ao promover o conceito de normalidade e vivência positiva difunde-se a desmedicalização do processo de TP e verificou-se redução das intervenções;
"Midwives' supervisory styles and leadership role as experienced by Norwegian mothers in the context of a fear of childbirth" Lyberg e Severinsson (2010) Objetivo: Descrever o estilo de supervisão e o papel de liderança da parteira experienciado por grávidas e puérperas em contexto de medo do parto	
População **13 Mulheres** **NE VI: Estudo Qualitativo**	- Reconhecimento mais evidente do papel da parteira a fim de fornecer alta qualidade e atendimento seguro dentro da complexidade dos cuidados contemporâneos. - Implementação da PBE num nível avançado exige modelos de supervisão diferentes para o desenvolvimento de competências e de liderança, fatores determinantes para a condução de melhoria contínua da saúde; - Implementação da gestão de habilidades e técnicas dos profissionais, com formação contínua;
"What is a good midwife? Insights from the literature" Borreli (2014) Objetivo: Identificar desfasamento de opinião/competências na perspetiva da parteira, formandos e mulheres	
População **6 Estudos** **NE I: RSL ou Meta análise**	- O conceito de parteira competente varia consoante o local e tipo de clientes, não havendo uma definição clara por escassez de informação nas expectativas e experiências; - A parteira deve ter vários atributos: Conhecimento teórico, Competências Profissionais, Qualidades Pessoais, Habilidades Comunicacionais e valores éticos e morais.

3.1 ANÁLISE REFLEXIVA DAS EVIDÊNCIAS E CONTRIBUTOS PARA A PRÁTICA

Na área de ESMOG surgem complexas questões às quais o EEESMOG procura dar uma resposta eficaz e eticamente correta à luz da reflexão. Para tal recorre à PBE, metodologia que interliga a prática e a teoria, num fluxo bidereccional. Nesta lógica procuraremos analisar a problemática em estudo perante a RSL.

Dos estudos em análise podemos constatar que todos incidem sobre a perspetiva que as mulheres têm do papel, das competências e da visibilidade do EEESMOG, nos vários momentos da gravidez, parto e puerpério. Portanto, existe uma forte necessidade de perceber o domínio de influência profissional e integração cognitiva do conceito pela sociedade, conforme identificado no início deste percurso formativo.

Borreli (2014), veio confirmar que existe um desfasamento entre as competências que o EEESMOG detém e aquelas que transmite à parturiente/acompanhante. Demonstra que, o conceito de EEESMOG competente varia de contexto e de população, permanecendo indefinida a percepção que as mulheres têm da sua competência, mesmo perante a demonstração da eficácia e eficiência da gestão do processo de saúde pelo EEESMOG. Mais acrescenta a OE (2015), que o paradigma da prestação de cuidados em ESMOG difere consoante os fatores contextuais existentes. Contudo o EEESMOG depara-se com o mesmo tipo de problemáticas, independentemente do país em que se encontre. Considera igualmente que o modelo biomédico, produziu subversão e adulteração dos princípios da prática do EEESMOG, sendo pertinente desenvolver estratégias para fortalecer a profissão como sejam: o recurso à evidência e o empoderamento da profissão, estratégia esta que, no nosso entender, deve ser enquadrada na filosofia de ação da prática de cuidados em ESMOG. No entanto, Sengane (2013), mostra características que a mulher valoriza no EEESMOG. Logo, as suas ações não passam despercebidas, mas ainda não são assumidas como competências socialmente enraizadas, especialmente se não houver contacto prévio com o grupo profissional. Neste âmbito, a OE (2015), vem alertar para o facto de existirem documentos legais, emitidos em Diário da República a 18 de fevereiro de 2011 (Regulamento 127/2011 e Regulamento 122/2011), que informam a sociedade e os profissionais do que esperar do EEESMOG e o seu espaço de atuação.

De salientar que, a pesquisa incluiu estudos com população que não era exclusiva de parturientes, mas todos eles incluíam este estadio e especificamente o Trabalho de Parto, conforme a pergunta PI[C]O elucida. Consideramos que tal acontecimento não causou desvantagem, uma vez que, para o momento do Trabalho de Parto, Parto e Puerpério Imediato apresentar sucesso, influencia largamente a experiência anterior que a parturiente tem, nomeadamente a vigilância da gravidez pelo EEESMOG, num processo contínuo de cuidados.

Interessante constatar na perspetiva de Coper e Lavander (2013), que as mulheres elucidadas perante o papel do EEESMOG demonstram preferência pelos seus cuidados e integram o empoderamento por ele realizado de forma espontânea, demonstrando confiança e

segurança nas competências do próprio. No entanto, se desconhecerem o papel do EEESMOG, perante a necessidade de cuidados de saúde, manifestam preferência pelo médico, atribuindo de imediato ao EEESMOG a função de avaliar e fornecer informações à equipa multidisciplinar, realizando cuidados standardizados e de tarefa. Neste sentido, as mulheres atribuem um sentido de doença à necessidade de cuidados e, desta forma, reconhecem o médico como principal prestador de cuidados à doença (Ulrich et al, 2003).

A OE (2015), identifica o facto da sociedade e os enfermeiros terem uma perceção incorreta e desconhecerem efetivamente o papel do EEESMOG e da Associação Pública Profissional como é a OE, apontando para as questões do porquê da mulher não estar a usufruir em pleno das competências do EEESMOG, para o facto dos serviços de saúde rentabilizarem pouco as mais-valias dos cuidados especializados e para o facto do EEESMOG não se afirmar no seu espaço de atuação.

Segundo Coper e Lavander (2013), o papel do EEESMOG só aparece salientado se for produzido essencialmente na ausência do médico, isento de influências do seu papel/estatuto. Ainda assim, as mulheres que mantêm preferência pelo médico, procuram o EEESMOG para esclarecimento da sua situação clínica e simplificação da linguagem utilizada por este. (Coper e Lavander, 2013).

Nesta perspetiva, depreendemos que para o EEESMOG conseguir transmitir informação clínica pertinente e adequada à mulher tem que, para além da habilidade na comunicação, deter competências literácicas e científicas para reproduzir o solicitado. Ora, inconscientemente a mulher atribui competências ao EEESMOG, mas não o assume como autónomo, apenas executante de uma ação delegada, o que contraria a realidade da prática autónoma em ESMOG e a liberdade de tomar decisões vinculativas baseadas nos conhecimentos clínicos dentro do âmbito da prática (Ribeiro, 2009), que permite identificar um problema ou um potencial problema (diagnósticos de enfermagem), que enquanto EEESMOG pode resolver, suportado num perfil de competências aprovado e publicado em Diário da República (Regulamento 127/2011 e Regulamento 122/2011).

Segundo os estudos e corroborando a análise de contexto, as mulheres quando têm contacto com o EEESMOG e são alvo das suas intervenções identificam a potencialidade dos cuidados, alterando o seu comportamento e reconhecendo as suas competências. No entanto, a sua condição social, educação e cultura é amplamente condicionado pela figura e estatuto profissional do médico. Nesta sequência, e tendo em conta McNelis (2013), a desmistificação do Trabalho de Parto e Parto, dá fortes contributos à resposta à problemática em estudo, e segue a linha que a OMS (1996) preconiza - a do parto natural, como um ato espontâneo de "dar à luz", sem necessidade de grandes intervenções médicas, como sejam, excesso de medicalização e instrumentalização do parto (OE, 2012).

A falta de consciência desta realidade leva, muitas vezes, políticos, dirigentes, gestores e enfermeiros a desconsiderar os referenciais publicados, subvalorizando o papel do EEESMOG, apesar de estarmos perante "mais do que uma especialidade em enfermagem - uma profissão com espaço próprio de atuação, registada na Classificação Nacional das Profissões e referência

específica na Classificação Portuguesa de Atividades Económicas para efeitos fiscais" (OE, 2015, p. 16.). Perante esta evidência, urge encorajar o EEESMOG a alterar práticas com recurso ao empoderamento social da profissão. Partilho da opinião da OE (2015), quando salienta a estratégia do empoderamento do EEESMOG como aspeto crucial na construção da nossa identidade profissional, estratégia apontada como finalidade deste percurso formativo.

Todos os estudos são consensuais no que se refere às competências e características do EEESMOG no âmbito desta temática, assim como da influência que outros profissionais de saúde têm na perenização da natureza/importância do papel do EEESMOG, o que não sendo desculpa, revela-se uma limitação na implementação prática do empoderamento social. No entanto, esta consensualidade nos estudos vem demonstrar a inquietação em conjugar esforços para a sua melhoria e a urgência em reconhecer o desempenho das suas atividades dando a conhecer esse papel aos outros que com eles se relacionam (Araújo, 2008).

Em relação às características que as mulheres identificam no EEESMOG, podemos afirmar que eleva o patamar da qualidade, segurança e confiança nos cuidados de saúde em ESMOG. Em todos os estudos, pelos discursos produzidos, conseguimos identificar a complexidade dos cuidados em ESMOG pois integra a complexidade da mulher na sua singularidade, nas várias vertentes do cuidar e essencialmente por prover um equilíbrio entre a competência relacional, técnica, científica e ético moral, característica profissional ímpar no campo da saúde. Nos estudos em análise, salientam-se a sensibilidade, a simpatia, a empatia, o suporte emocional, as habilidades comunicacionais, a promoção do empoderamento da parturiente/acompanhante, a promoção do papel parental e da relação da tríade; a promoção de um ambiente tranquilo, respeitoso; a promoção do conceito de normalidade em relação ao Trabalho de Parto, este último, factor determinante na opção pelo EEESMOG como cuidador (McNelis, 2013; Sengane, 2013; Cooper e Lavander , 2013).

Estas caraterísticas anteriormente mencionadas descrevem a natureza, as condições facilitadoras e dificultadoras e os padrões de resposta (processo e resultado) comuns aos processos de transição que guiam as intervenções do EEESMOG. Tendo em conta a Teoria das Transições de Meleis *et al.* (2000), permite pôr em prática estratégias de prevenção, promoção e intervenção terapêutica face às transições que a grávida, parturiente e puérpera/acompanhante vivenciam. Ou seja, perante a eminência de uma transição, desencadeada por eventos ou pontos críticos, aqui entendida como o processo de transição durante o Trabalho de Parto e Parto e o resultado da mudança de papéis provocada pelo nascimento, o EEESMOG contempla no processo a percepção da alteração e os padrões de resposta ao mesmo, assistindo nas mudanças e exigências que as transições provocam, de modo que a parturiente/acompanhante seja capaz de incorporar as mudanças na sua vida, alterando o seu comportamento e redefinindo a sua identidade.

Perante os cuidados prestados pelo EEESMOG, as parturientes/acompanhantes sentiram equidade, coresponsabilidade, empoderamento, continuidade de cuidados e decisão informada, que influenciou e promoveu uma vivência positiva do Trabalho de Parto, a diminuição da

intervenção medicalizada e a gestão pela própria do processo de saúde (Sengane, 2013). Nesta perspectiva, Callister (1995) e Turnbull *et al.* (1996), citados pela OE (2015), salientam que, as mulheres que são atendidas pelo EEESMOG tendem a apresentar menores taxas de intervenção, tais como: realização de ecografias, recurso à analgesia epidural, uso de monitorização cardíaca fetal contínua, realização de cesarianas e de indução de Trabalho de Parto. As principais vantagens identificadas foram a redução do uso de analgesia regional, menor número de episiotomias e de partos instrumentados. Vários estudos consultados pela OE (2015), demonstram consistentemente que os resultados clínicos da assistência prestada pelo EEESMOG apresentam menos complicações no parto e níveis elevados de satisfação relativamente aos cuidados e à forma como estes lhes foram prestados. Também neste aspeto, a evidência científica revela que uma maior satisfação da mulher com a sua experiência de parto está efetivamente, associada ao parto natural e sobretudo ao tipo de assistência prestada (OE, 2015).

Neste sentido, embora nos estudos filtrados o empoderamento seja sempre referido na perspetiva da capacitação da mulher, está subjacente no estudo de Lyberg e Severinsson (2010), a necessidade de apoiar o EEESMOG no reconhecimento mais evidente do seu papel e para tal exige modelos de supervisão, para o desenvolvimento de competências e de liderança, fatores determinantes para a condução de melhoria contínua da saúde, uniformização de procedimentos e evidência social sobre os seus contributos para a saúde, fazendo ressaltar a necessidade do empoderamento do EEESMOG canalizada para a vertente social. Ainda assim, mais acrescenta Lyberg e Severinsson (2010) que, a supervisão influência a qualidade dos cuidados e requer empoderamento do EEESMOG na liderança das suas próprias competências, a fim de desenvolver a prática, prever desafios, mudanças e promover a prática baseada na evidência.

Em continuidade, a OE (2015), aponta que as políticas de saúde centradas na mulher, enfatiza o desenvolvimento de competências do EEESMOG, garante a escolha no acesso ao tipo de cuidados na assistência pré e pós-natal e ao local de parto, assim como, dá significado e incentiva o sentido de liderança e o seu próprio empoderamento, enquanto profissão/categoria, detentora de identidade profissional.

O facto desta perspetiva do empoderamento social aparecer salientada por Lyberg e Severinsson (2010), nomeando a necessidade de apoiar o reconhecimento mais evidente do papel do EEESMOG, reforça a evidência da necessidade da problemática e dá subsídios à qualidade e segurança dos cuidados em ESMOG. Destas estratégias, a OE (2015), destaca a importância de nutrir/estimular e empoderar o EEESMOG, encorajar a diversidade, complexidade e insubstitualidade de ESMOG, desenvolvendo o sentido de solidariedade entre pares e de estratégias políticas que as possibilitem.

Perante a análise destes Estudos, entendemos que o tema é transversal nos contextos de ação em ESMOG, apesar das diferenças culturais e de amplitude de competências legisladas em cada um deles. De referir que os Estudos incluem o Trabalho de Parto em domicílio, contexto de ação que não é contemplado na nossa realidade. Ainda de salientar que, quando o contexto de ação é o domicílio, todo o processo de Trabalho de Parto e Parto é realizado autonomamente pelo EEESMOG e são planeados os cuidados antecipadamente e perante o requisito específico da

mulher. Nesta sequência, não deixa de ser curioso a distinção entre contextos e a atribuição de papéis para cada um deles, associando mais uma vez, o parto medicalizado ao hospital e o parto não medicalizado, dito normal, no domicílio. Nos artigos de Sengane (2013) e McNelis (2013), houve também referência de mulheres que inicialmente recusaram o Trabalho de Parto em meio hospitalar, pela razão anterior, mas que impedidas de o fazer, surpreenderam-se por usufruírem de uma vivência positiva do Trabalho de Parto e Parto realizado pelo EEESMOG no hospital, obedecendo com rigor ao seu plano de parto. Neste ponto, observamos a transformação de paradigma nos cuidados em ESMOG e da descentralização do modelo biomédico. De salientar a sensibilidade e competências do EEESMOG, onde incluímos sabedoria e perícia, na realização do Trabalho de Parto em domicílio, completamente desprovidos de meios complementares de diagnóstico e de apoio diferenciado. Fortalecendo a ideia, Dary-Strirk (2012), citado pela OE (2015), sublinha que o objetivo máximo do EEESMOG é contribuir para a construção de um mundo onde a mulher/RN tenham acesso ao cuidados em ESMOG.

Por outro lado, Sengane (2013) e McNelis (2013), demonstram que o papel do EEESMOG, na perspetiva daquilo que as mulheres esperam dele, corresponde ao que é definido pela disciplina e perante os cuidados prestados, são valorizados e ainda superaram as expectativas daquelas que inusitadamente foram alvo de cuidados pelo EEESMOG. Portanto, se o papel/competências do EEESMOG são identificáveis, demonstra que este consegue transmitir, mas não o faz com eficiência suficiente para criar consciência coletiva. Portanto, enfatiza um modelo de cuidados centrado na mulher e na resposta às suas reais necessidades, permite escolhas informadas e capacita a mulher no compromisso com a promoção do Trabalho de Parto e Parto fisiológico. Segundo a OE (2015), a filosofia de cuidados em ESMOG na sua essência é fortemente enraizada num modelo de assistência em que o EEESMOG trabalha em parceria com a mulher, garantindo continuidade de cuidados e melhoria do processo normal de parir e nascer.

Esta pesquisa veio reforçar três pontos fundamentais que salientamos na problemática em estudo e que nos deu motivo para a investigação como sejam: o real desfasamento entre as competências que o EEESMOG demonstra e a perspetiva das mulheres, justificando a pertinência da problemática em estudo; as características/competências do EEESMOG são identificáveis, da qual descrevemos igualmente como fundamentais na gestão do processo de cuidados com segurança e qualidade e a necessidade de valorizar e atribuir representação social, onde salientamos a atitude clínica do EEESMOG, com expressão de autonomia funcional, que reflete o Saber Científico, o Saber da Prática e o Saber Pessoal e que, segundo Lyberg e Severinsson (2010), é transferível para a prática com a utilização da supervisão e liderança do EEESMOG, promovendo o seu empoderamento social.

Nenhum dos Estudos pesquisados oferece solução à problemática em análise, mas dá fortes contributos nesse sentido. Na prática diária, os contributos que a PBE nos transferiu foi que, a ESMOG é insubstituível e veio permitir uma ação autónoma inigualável em Enfermagem. Esta autonomia em contexto de trabalho, é um requisito para dar visibilidade às nossas práticas,

exponenciando a qualidade da exposição social no sentido da obtenção de uma representação social (Ribeiro, 2009).

De salientar a ausência à referência da autonomia nos estudos analisados, facto que depreendemos não ser o enfoque dos estudos e também por estar implícito que o EEESMOG detém autonomia em todos os processo de Trabalho de Parto, Parto e Puerpério imediato. Ainda assim, consideramos um conceito de extrema importância devido ao nosso estadio de formação e em que a realização da especialidade nesta área permitiu alcançar. Só o simples facto da profissão ter conquistado autonomia através da evolução do conhecimento da disciplina de enfermagem e do forte contributo para os ganhos em saúde, não bastou para o reconhecimento merecido, mas fica demarcado que a ESMOG é exímia na conjugação da sabedoria e perícia nos cuidados que presta durante o Trabalho de Parto (Ribeiro, 2009).

Mais acrescenta Mundinger (1980), citado por Ribeiro (2009), que as competências em ESMOG conferem poder para determinar o que é preciso ser feito em relação aos cuidados à mulher, agir de acordo com a avaliação feita e aceitar a responsabilidade pelas decisões tomadas, a partir da qual aperfeiçoamos a Sabedoria em ESMOG, grande componente para o sucesso das práticas.

Por outro lado, de salientar que, a legitimidade do estatuto leva a que as competências sejam indubitavelmente credíveis e expectáveis, sem que, em tempo algum, sejam alvo de avaliação e julgamento. Por isso, concluímos que o EEESMOG ainda não detém estatuto para o efeito pois tem que, constantemente, demonstrar e replicar as suas competências, sendo realmente criativo, inovador, flexível e produtivo, do ponto de vista da cooperação com a mulher, com a equipa multidisciplinar e com a Instituição de Saúde.

Portanto, devido a estas limitações sociais, o EEESMOG passa o tempo a tentar superar-se, motivo pelo qual a ESMOG renova-se a cada reflexão.

Em síntese, o empoderamento como reflexo das competências do EEESMOG, é descrito como um processo construído com base na relação estabelecida entre o EEESMOG e a parturiente/acompanhante, assente em competências cognitivas, de comunicação, técnicas e relacionais sólidas, que perspetiva a consciencialização do papel do EEESMOG e o envolvimento deste no seu processo de saúde, demonstrando efetivamente que, quando este passo é conseguido, os resultados sensíveis aos cuidados de enfermagem verificam-se, sendo certo que o empoderamento da parturiente/acompanhante tem de ser desenvolvido estrategicamente, para que a percepção das competências do EEESMOG se enraízem, pois ocorre interativamente e em reciprocidade e difunde-se na família, amigos e meios de comunicação.

Assim, perante esta análise reflexiva, as evidências são: o EEESMOG pertence a um grupo profissional que apresenta competências e capacidades regulamentadas, tendo por base o conhecimento disciplinar de Enfermagem, com um campo de atuação e um foco próprio, o Cuidar Multidisciplinar. Contudo, perante a mulher/família/sociedade, perante os pares/instituição e no seio do grupo profissional, o crescimento e obtenção de competências científicas, técnicas, humanas e ético morais, o alargamento e reforço de poder decorrentes deste constructo científico, não produziu transformações sociais de reconhecimento e garantia epistemológica. Propõem-se

por isso implementar o empoderamento do próprio grupo profissional através da melhoria da supervisão dos processos e do papel da liderança com o grupo alvo de cuidados, uma vez que, o EEESMOG assume responsabilidade na gestão do processo de cuidados, cria e recria um ambiente de trabalho com base na complexidade do contexto de ação e lidera a gestão dos processos de saúde, construindo como reflexo das suas práticas o empoderamento social do EEESMOG. Implementa igualmente a gestão de habilidades e técnicas dos profissionais com formação contínua, através do empoderamento social do EEESMOG, nomeadamente reforçando a autonomia, responsabilidade, atitude clínica e poder no seu contexto de ação, demonstrando à parturiente/acompanhante que é o mediador do processo de cuidados e que assume responsabilidade pela gestão do seu processo de saúde porque tem competências para o efeito.

4. CONCLUSÃO

No decorrer deste percurso e perante o desenvolvimento de atividades em múltiplos contextos da área de ESMOG, optou-se por uma área temática central e transversal, integrada no regulamento de competências específicas do EEESMOG.

De acordo com Amendoeira (2004), a enfermagem, na qual incluímos a ESMOG, constitui-se como uma área do saber útil à sociedade, a partir do desenvolvimento de um conjunto de atividades que são essenciais à vida, mas ainda não são reconhecidas socialmente como fazendo parte de um campo autónomo de saber e de intervenção.

A ESMOG integra na sua função e filosofia de cuidados a complexidade de cada mulher e a satisfação das suas necessidades conjugando com mestria o campo de saberes, o campo de atuação e o campo social. Contudo, a visibilidade das suas práticas e a qualidade da sua exposição social aparece condicionada a factores culturais e sociais que impede de criar uma consciência coletiva sobre a verdadeira essência dos cuidados prestados pelo EEESMOG, no bloco de partos.

A evolução do conceito e da disciplina veio recriar a potencialidade dos cuidados como requisito para o estatuto e ação autónoma definida por legislação. Houve então mudanças no padrão de cuidados e no modelo adotado, que colocando a mulher no centro de cuidados, demonstra desfasamento total do modelo biomédico e traça uma nova filosofia do Cuidar Multidimensional, no bloco de partos.

A filosofia de cuidados em ESMOG no bloco de partos, consiste no estabelecimento de uma forte relação de confiança com a parturiente/família, na continuidade de cuidados e na manutenção da normalidade, face aos diversos estadios que enfrenta, num momento que marca uma transição de grande relevo na vida da mulher/casal/família (Meleis, 2007). No cuidado centrado na mulher, o EEESMOG, incentiva e promove a tomada de decisão informada, a gestão do seu processo de saúde com autoeficácia, que abrange as suas crenças e valores, isento de julgamentos. É um processo interativo, dinâmico e baseia-se na integração do conhecimento derivado das artes e das ciências, fortalecida pela experiência, pesquisa e elo cooperativo com outros profissionais de saúde, da qual emerge a Sabedoria, que caracteriza os cuidados prestados pelo EEESMOG (OE, 2015). Todo este plano de ação, em contexto de bloco de partos, vai influenciar as escolhas que as mulheres fazem, embora estas estejam condicionados a normas culturais e sociais do meio onde estão inseridas, mas também pelo tipo de cuidados que lhes é oferecido e pelo modelo assistencial disponibilizado (OE, 2015).

Neste percurso entendeu-se que, o EEESMOG deve utilizar as suas capacidades, competências e habilidades na finalidade da sua ação, através delas adquirir autonomia, atitude

clínica, sabedoria e responsabilidade para a ação e promover o seu reconhecimento através do Empoderamento Social do EEESMOG.

O EEESMOG quando desenvolve a sua intervenção não pode expectar resultados visíveis a curto prazo, por isso a sua prática deve ser sustentada e projetada a médio e longo prazos, facto que conseguirá quando revelar e demonstrar a importância do seu papel, sendo que aqui a cientificidade da sua prática e a arte de cuidar, entendida como Sabedoria, deve ser exponenciada.

A percepção de que esta é uma especialidade que garante ao EEESMOG uma "ação autónoma inigualável a qualquer outra especialidade em enfermagem" (Galhardo, 2004, p.12), dá-nos clara segurança para passar à fase seguinte, a de criar consciência coletiva sobre o Cuidar em Enfermagem em ESMOG e especificamente em contexto de bloco de partos. Pensamos que, perante a diversidade de áreas de influência dos cuidados em ESMOG e a crescente condição da mulher/RN/família e da saúde, os cuidados prestados pelo EEESMOG são, sem dúvida, uma exigência no panorama da Saúde Materna e Obstétrica em Portugal, às quais devem ser sustentadas por elevados níveis de competências e projetadas como reflexo de um cuidar *Premium*.

De salvaguardar que, o EEESMOG, no espaço europeu, vê reconhecidas as suas competências, conferindo-lhes uma capacidade de intervenção diferenciada sobretudo no que se relaciona com as intervenções na presença de situações patológicas ou de doença concomitante com a gravidez em detrimento da parteira que adquiriu formação pela Confederação Internacional das Parteiras, e não na sequência do curso de licenciatura em enfermagem (OE, 2015). Neste sentido, o EEESMOG desempenha o processo de cuidados com eficácia, tem um largo e profundo espectro de conhecimentos e uma capacidade exímia em dar resposta às necessidades da parturiente/acompanhante em bloco de partos, ou seja, o seu nível de competência supera a qualidade e excelência na resposta técnica, humana, científica, ética, moral e cultural. Por outro lado, espera-se do EEESMOG um contributo no sentido do aumento do repertório de recursos internos enquanto grupo profissional para lidar com os desafios do Empoderamento Social, que requer adaptação, auto controlo e resiliência (Araújo, 2008). Ou seja, o domínio das relações sociais com o meio, uma boa utilização das normas organizacionais, uma boa rede de comunicação, podem ser outras formas de legitimação desse poder/reconhecimento social.

Contudo, os desafios prementes demandam a fundamentação do conhecimento próprio da ESMOG, o reconhecimento da prática e dos saberes e, consequentemente, a construção de novos paradigmas de produção de saberes emergentes da realidade social, que promova uma homogeneidade de atitudes clínicas nos processos de autonomia funcional e interdisciplinaridade da prática do EEESMOG.

É imperioso que o EEESMOG, apropriado do quadro regulador, desenvolva reflexão sobre as práticas individuais à luz dos referenciais definidos, que promova reflexão sobre as práticas clínicas do grupo profissional e produza resultados sensíveis ao Empoderamento Social, avaliados

pelos ganhos em saúde e pelo reconhecimento social das suas competências e autonomia funcional.

Ainda assim, o EEESMOG precisa compreender efetivamente o seu poder e transformá-lo em poder de participação e de decisão, no sentido de que as respostas desenvolvidas possam demonstrar e provocar reconhecimento da complexidade das suas ações, da diversidade de conhecimentos, responsabilidade e autonomia. No entanto, mediar esse processo é complexo, nomeadamente pela abrangência multidimensional deste poder, assim como, de gerar representação social do mesmo.

Segundo a OE (2015, p. 18), " Definido o perfil de competências importa contribuir para a consciencialização coletiva e apropriação individual, mas também assumir atitudes e comportamentos profissionais diários que revelem independência, responsabilidade, conhecimento, respeito e dignidade profissional." Esta, refere ainda que o empoderamento, aspeto crucial na construção da identidade profissional do EEESMOG, deverá ser desenvolvido diariamente entre colegas. Para isso, deve ser desenvolvido e fortificado o modelo de cuidados em ESMOG, criar redes de apoio, oferecer suporte dentro do grupo, para desenvolver estratégias de mudança e superar contextos destrutivos, assim como, desenvolver estratégias de *coping* perante as adversidades de um contexto em mudança. No que concerne às estratégias políticas, estas passam por valorizar os relacionamentos interprofissionais, realçar benefícios a longo prazo das boas experiências de parto e analisar os contributos dos cuidados (OE, 2015).

Portanto, estamos situados na abordagem de um fenómeno individual e coletivo e na atribuição de significados, capazes de mudar ideias e padrões afim de gerar culturalização, ou seja, gerar atitudes que alterem comportamentos e formalize um fenómeno coletivo. Mas para gerar fenómenos coletivos sociais, devemos começar pela capacitação do grupo que vai formalizar a culturalização. Terá que ser o EEESMOG a primeiro capacitar-se para depois gerar atitudes coletivas a nível social.

Propõem-se por isso, criar realidades para que a parturiente/acompanhante compreenda a produção das funções do EEESMOG e que este demonstre com que competências podem contar, promovendo confiança nos processos de saúde por si geridos. Perspetiva-se então empoderar socialmente o EEESMOG, através da integração cognitiva do conceito (significado, utilidade, competências), assim como, orientar as percepções e os julgamentos numa realidade socialmente construída.

Como limitação deste processo identificamos o facto de não passar a um plano de ação e implementação na prática. Consideramos de extrema importância esta metodologia de narrativa de ação como contributo para a PBE, pois as fragilidades são apenas mensuráveis na prática e podendo ser objecto de reflexão trazem subsídios que, para além de estarem perfeitamente adequados ao contexto de ação, são por isso mesmo, aplicáveis de imediato e passíveis de resultados.

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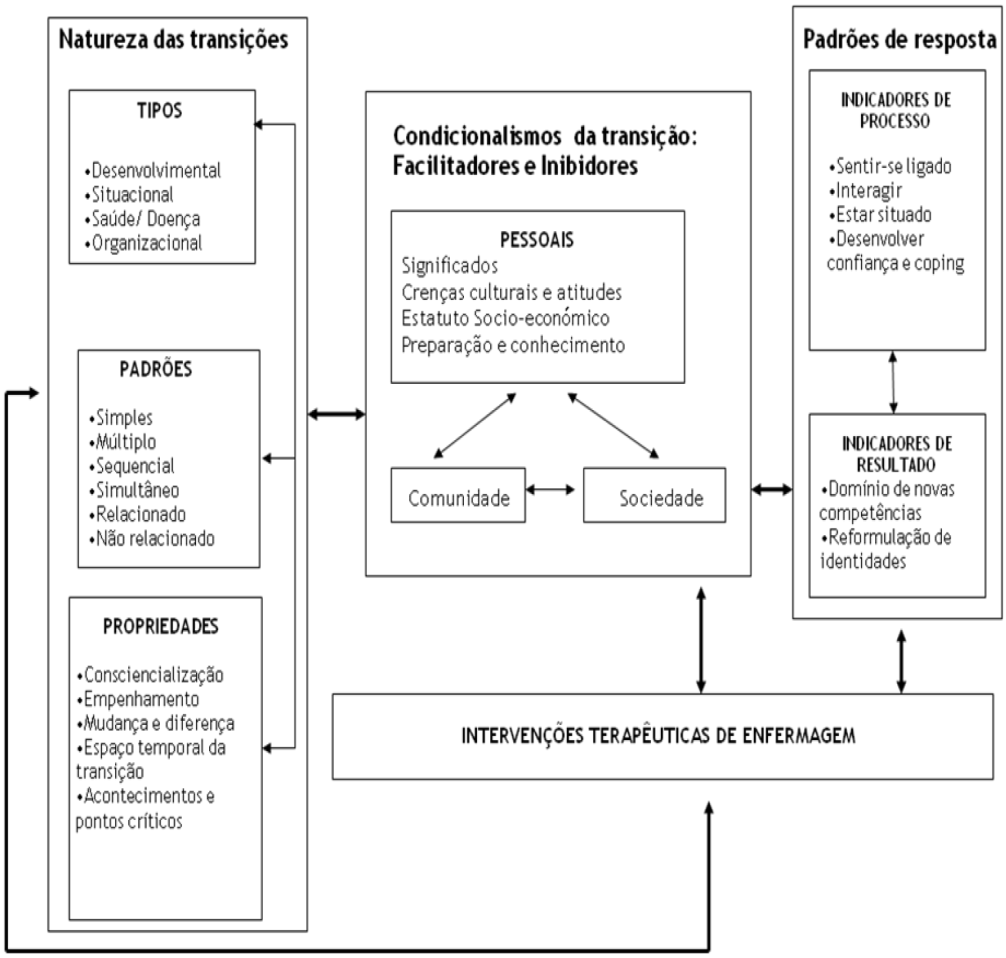
ANEXOS

ANEXO I

ESQUEMA DA TEORIA DAS TRANSIÇÕES DE MELEIS et al. (2000)

Esquema da Teoria de Meleis et al. (2000)



ANEXO II

RESULTADO DE PESQUISA DOS DESCRITORES

MeSH Heading	**Midwifery**
Tree Number	H02.478.676.416
Annotation	SPEC: SPEC qualif; check also tag PREGNANCY
Scope Note	The practice of assisting women in childbirth.
Entry Term	Midwife
Entry Term	**Midwives**
Entry Term	Traditional Birth Attendant
See Also	Home Childbirth
See Also	Nurse Midwives
Allowable Qualifiers	CL EC ED ES HI IS LJ MA MT OG SN ST TD
History Note	66; was MIDWIVES 1963-65
Date of Entry	19990101
Unique ID	D008880

MeSH Heading	**Labour**
Tree Number	**G08.686.785.760.769.326**
Annotation	check tags FEMALE & PREGNANCY; LABOR, INDUCED is also available
Scope Note	The repetitive uterine contraction during childbirth which is associated with the progressive dilation of the uterine cervix (CERVIX UTERI). Successful labor results in the expulsion of the FETUS and PLACENTA. Obstetric labor can be spontaneous or induced (LABOR, INDUCED).
Entry Term	Obstetric Labor
See Also	**Natural childbirth**
See Also	**trial of labor**
Allowable Qualifiers	**BL CF DE EH GE HI IM ME PH PX RE UR**
History Note	2003
Date of Entry	19990101
Unique ID	D007743

MeSH Heading	**Social Change**
Tree Number	I01.880.853.400
Tree Number	N01.824.737
Annotation	specify geog if pertinent
Scope Note	Social process whereby the values, attitudes, or institutions of society, such as education, family, religion, and industry become modified. It includes both the natural process and action programs initiated by members of the community.
Entry Term	Community Development
Entry Term	Development Plans
Entry Term	Modernization
Entry Term	Social Development
Entry Term	Social Impact
Entry Term	**Social** * Utilizou-se como palavra chave por produzir pesquisa adequada, com tradução de um impacto social e de um desenvolvimento social da temática, em associação a outras palavras chave
Allowable Qualifiers	HI
Previous Indexing	Social Conditions (1966-1967)
Previous Indexing	Sociology (1966-1967)
History Note	68
Date of Entry	19990101
Unique ID	D012922

MeSH Heading	**Power (Psychology)**
Tree Number	F01.658.780
Scope Note	The exertion of a strong influence or control over others in a variety of settings--administrative, social, academic, etc.
Entry Term	**Empowerment**
Entry Term	Power
Entry Term	Power, Personal
Entry Term	Power, Professional
Entry Term	Power, Social
See Also	Social Control, Informal
Entry Version	POWER PSYCHOL
History Note	88
Date of Entry	19870409
Unique ID	D011209

ANEXO III

QUADROS DAS CONJUGAÇÕES DAS PALAVRAS CHAVE

Midwives	**2747**
Labour	**2920**
Social	**31425**
Empowerment	**3135**

Midwives + Labour	**134**
Midwives + Social	**2048**
Midwives + Empowerment	**291**

Midwives + Labour + Social	**26**
Midwives + Labour + Empowerment	**110**
Midwives + Social + Empowerment	**251**

Midwives + Labour + Social + Empowerment	**98**

ANEXO IV

PROTOCOLO DE PESQUISA

Protocolo de Pesquisa

Empowerment
- CINAHL
- MEDLINE
- MEDIC LATINA

Midwives
Labour
Social
- CINAHL
- MEDLINE
- MEDIC LATINA

Filtro cronológico 2009-2015
Full text
Pesquisa na Plataforma EBSCO
Produziu **3,135** Artigos

Filtro cronológico 2009-2015
Full text
Pesquisa na Plataforma EBSCO
Produziu **251** Artigos

Conjugação dos Descritores

Midwives AND Labour AND Social AND Empowerment

(Validação na Base de dados Internacional MeSH Browser)

Filtro Cronológico 2009 - 2015
Full Text

Pesquisa na Base de Dados EBSCO Produziu **98** Artigos

Catalogação dos artigos de acordo com a Evidência demonstrada e Apreciação Crítica
15 Artigos selecionados

Após a Leitura Integral dos 15 Artigos Foram selecionados Para Serem Incluídos no Estudo 5 Artigos

Critérios de Inclusão	Critérios de Exclusão
- Estudos onde a população alvo fosse grávidas, parturientes, puérperas ou EEESMOG; - Estudos desenvolvidos em contexto de ESMOG, com especial enfoque no período de Trabalho de Parto em meio hospitalar; - Estudos onde a abordagem de cuidados prestados por EEESMOG fosse apresentada, assim como, expetativas/perceção sobre o seu papel, competências e autonomia; - Estudos onde a abordagem do empoderamento na vertente da mulher cuidada e na vertente do grupo profissional EEESMOG fosse apresentada.	- Estudos em que a população alvo não fosse grávidas, parturientes, puérperas ou EEESMOG; - Estudos com data anterior 2009; - Estudos sem correlação com a temática em estudo. - Estudos com enfoque apenas perspetiva histórica dos cuidados em ESMOG; - Estudos direcionados a dispositivos médicos e a plataformas informáticas; - Estudos em que a temática focava situações de abortamento; - Estudos com enfoque na satisfação/motivação no trabalho em termos de políticas de gestão da instituição de saúde; - Estudos em contexto exclusivo de cuidados de saúde primários e cuidados de ESMOG prestados em domicílio.

ANEXO V

RESUMO DOS ARTIGOS PESQUISADOS INCLUÍDOS

"Women's Persceptions of a Midwife's Role: An Initial Investigation" Cooper, T. Lavander, D. (2013). *British Journal of Midwifery*, 264-273, April, Vol 21, Nº 4. Mark Allen Publishing Ltd	
Participantes	**9 Mulheres** 4 Grávidas e 5 puérperas das quais 5 seguidas pela parteira e 4 por Médicos Obstétras
Objetivos	- Explorar a percepção das mulheres sobre o papel da parteira: o que sabem sobre o papel da parteira? como diferenciam o papel da parteira em relação aos outros profissionais de saúde? que fatores contribuem na identificação do papel da parteira? O conhecimento do papel da parteira influencia nas escolhas de saúde das mulheres? que competências as mulheres esperam da parteira?
Resultados	- A percepção dos cuidados difere se as mulheres foram acompanhadas pela parteira ou pelo médico; - A parteira promove o Empoderamento da mulher, dando suporte, garantia e coragem, que as capacita para a gravidez, TP, parto e Pós-Parto; - O empoderamento permitiu um parto normal sem utilização de analgesia/anestesia, produzido pela autoconfiança e autogestão, e promoveu uma vivência positiva do parto; - Mostrou como a família/amigos e meios de comunicação influênciam as expectativas do parto e do papel da parteira, assim como experiências pessoais anteriores; - As mulheres acompanhadas pela parteira utilizaram as várias fontes de informação, dialogaram e expuseram dúvidas. Sentiram que o principal papel deste é emponderar a mulher durante a gravidez, TP, Parto e Pós-parto e que a competência técnica é necessária no processo, mas sentem mais a componente relacional; - Os partos realizados por médicos não permitiram o empoderamento da mulher e estas aceitaram a condição do conhecimento autoritário e não lhes foi permitido utilizar um plano de parto; - As mulheres acompanhadas por médicos identificam o papel da parteira a cumprir tarefas, monitorizado e utilizando tecnologia. Referem que observam a parteira a avaliar e a fornecer a informação ao médico que toma a decisão, executa ou delega a função. Salientam o papel da parteira em simplificar a linguagem/comunicação utilizada pelo médico; - As mulheres acompanhadas pela parteira demonstraram confiança na prestação de cuidados e referem não sentir necessidade da presença do outro profissional de saúde; - O papel da parteira só aparece ressaltado se for produzido essencialmente na ausência do médico, isento de influências do seu papel/estatuto.
Nível Evidência: VI	**Tipo de Estudo: Qualitativo**

"Mother's expectations of midwives care during labour in a public hospital in Gauteng" Sengane, M. (2013). *Curations* 36 (1), Art. #320, 9 pages, Copyrigth©2013. The Autothors. Licensee: AOSIS OpenJournals.	
Participantes	Sem especificação da amostra do estudo
Objetivos	- Determinar as expectativas das mulheres perante os cuidados prestados pela parteira durante o TP e parto
Resultados	- Na relação entre a mulher e a parteira identificou-se equidade, coresponsabilidade, empoderamento, continuidade de cuidados, decisão informada; - As mulheres esperam que a parteira: Realize o acolhimento com enfoque nas necessidades, no estado emocional, problemas sociais e conhecimentos e depois a avaliação física; Promova medidas de conforto (massagem terapêutica, posições de conforto, medidas farmacológicas), toque terapêutico (como atitude cuidadora e de encorajamento), hidratação oral e higiene; No 2º estadio de TP promova uma posição de conforto (opção pela preferência), técnica da episiotomia otimizada, higiene e conforto, hidratação oral e avaliação do bem estar materno fetal eficaz; Mostrem sensibilidade, simpatia, empatia na resolução de problemas; Mostre habilidades comunicacionais (informem de forma clara sobre os procedimentos, as suas ações, resultados, termos utilizados no TP, Parto e Pós-parto e felicitem pelo nascimento); Permitam e incentivem a presença do pai/acompanhante significativo, promovendo a relação da tríade familiar e do papel parental. - A parteira deve fazer formação contínua em competências relacionais, comunicacionais.
Nível Evidência: VI	**Tipo de Estudo: Qualitativo**

"Women's experiences of care during labour in a midwifery-led unit in the Republic of Ireland" McNelis, M. (2013). *British Journal of Midwifery*, 622-631, September, Vol 21, Nº 9. Mark Allen Publishing Ltd	
Participantes	**8 Mulheres**
Objetivos	- Explorar as experiências das mulheres em cuidados prestados pela parteira, numa Unidade de Obstetrícia: Descrever as experiências das mulheres durante o TP; Descrever aspetos dos cuidados prestados pela parteira que influenciem as experiências das mulheres durante o TP; Informar a parteira sobre os cuidados prestados e recomendações.
Resultados	- A essência do cuidado da parteira é um ambiente calmo, tranquilo e relaxante, através do respeito demonstrado pelas mulheres e pelas suas decisões na gestão do seu processo de TP e Parto; - Ao promover o conceito de normalidade em relação ao processo TP e Parto, a parteira desenvolve um ambiente terapêutico, com a centralidade dos cuidados na mulher e difunde a desmedicalização do processo; - O estudo encontrou 2 categorias de experiência: o ambiente calmo/terapêutico e o empoderamento da mulher, com transmissão de segurança e proteção; - Para gerar ambiente terapêutico foi determinante o papel da parteira, pois as mulheres sentiram-se acompanhadas, relaxadas, influenciando de forma positiva a vivência do processo de TP e Parto; - As mulheres referiram ter sido alvo de privacidade, cuidados personalizados, suporte emocional, respeitadas na sua condição de saúde, capazes de tomar decisões sobre o seu processo de saúde e verificou-se redução das intervenções durante o TP e Parto.
Nível Evidência: VI	**Tipo de Estudo: Qualitativo**

"Midwives' supervisory styles and leadership role as experienced by Norwegian mothers in the context of a fear of childbirth" Lyberg, A, Severinsson, E (2010). *Journal of Nursing Management*, 391-399, 18, The Authors. Journal compilation © 2010 Blackwell Publishing Ltd.	
Participantes	**13 Mulheres**
Objetivos	- Descrever o estilo de supervisão e o papel de liderança experienciado por grávidas e puérperas em contexto de medo do parto
Resultados	- Este estudo sublinha a necessidade de apoio à parteira no reconhecimento mais evidente do seu papel a fim de fornecer alta qualidade e atendimento seguro dentro da complexidade dos cuidados contemporâneos. A PBE num nível avançado é necessário e exige modelos de supervisão diferentes para o desenvolvimento de competências e de liderança, fatores determinantes para a condução de melhoria contínua da saúde. - Estilo de supervisão da parteira: Criar uma relação de confiança e cuidado Estar sensível às necessidades e desejos individuais e atuar de acordo com as mesmas Habilidade de promover o esclarecimento com base na esperança Demonstrar capacidade na resolução de problemas Ser compreensivo Identificar e explicar as razões para o medo do parto e mostrar vontade, prontidão e coragem para apoiar as mulheres - Papel de liderança da parteira Assumem responsabilidade na gestão do processo, de criar um bom ambiente de trabalho e de empoderar a mulher; Implementar a gestão de habilidades e técnicas dos profissionais, com formação contínua;
Nível Evidência: VI	**Tipo de Estudo: Qualitativo**

"What is a good midwife? Insights from the literature" Borreli, S. (2014). *Midwife*, 3-10, 30. Front matter ©2013 Elsevier Ltd.	
Participantes	**6 Estudos** **Perspetiva da Parteira, formandos, mulheres/acompanhantes**
Objetivos	- Revisão de literatura sobre o que é considerado ser uma parteira competente e que valor é atribuído ao mesmo pela mulher afim de identificar desfasamento de opiniões/demonstração de competências
Resultados	- A parteira deve ter vários atributos: Conhecimento teórico, Competências Profissionais, Qualidades Pessoais, Habilidades Comunicacionais e valores éticos e morais. - O conceito de parteira competente varia consoante o local onde desempenha a sua atividade e que tipo de clientes têm, não havendo uma definição; - Não está claro se, o que a parteira se define, corresponde à percepção que as mulheres têm das suas competências; - A revisão da literatura mostra alguma informação sobre o que a mulher valoriza na parteira, mas há uma escassez de informação nas expectativas e experiências das nulíparas; - A revisão da literatura procura estimular o debate e a reflexão acerca da natureza do papel da parteira, competências e qualidades afim de corresponder às expectativas das mulheres perante as competências apresentadas pela parteira e aumentar a satisfação da experiência do parto realizado por este.
Nível de Evidência: I	Nível de Evidência I: Revisão Sistemática ou Meta-análise de estudos experimentais relevantes

ANEXO VI

ARTIGOS PESQUISADOS

RESEARCH

Women's perceptions of a midwife's role: An initial investigation

Abstract

The role of the midwife has evolved over the years, influenced by a number of social, political and educational factors (Department of Health and Social Security (DHSS), 1970; Her Majesty's Stationery Office (HMSO), 1984; Tew, 1986; Donnison, 1988, Department of Health (DH), 1993; Kitzinger, 2005; DH, 2007; National Institute for Health and Clinical Excellence (NICE), 2008). However, little is known about how the contemporary role of the midwife is perceived (Lavender and Chapple, 2002). Some changes were not based on any evidence or health economics (DHSS, 1970; HMSO, 1984). Health costs have predominantly been based on the cost of service provision, rather than costs of unnecessary intervention being considered. The *Birthplace* study did take into account health economics including intervention costs (Shroeder et al, 2012); therefore, if service changes are made to reflect the benefit of health economics with the new maternity pathway payments (DH, 2012), this may impact on how the role of the midwife is perceived in the future. This qualitative study was conducted to gain understanding of women's perceptions of the role of the midwife. Four focus groups were conducted (n=9) to identify perceptions of the midwife's role from women experiencing care from different care providers; women in different periods of their childbearing experience; women who had previous experience of childbearing; and those who had no previous experience of childbearing. Thematic analysis of the transcripts identified four themes: empowerment influence of midwives; influences of media, friends and family; role of monitoring and technology; and influence of doctors. The conclusion was that the model of care and care provider influenced women's perceptions of the role of the midwife. Women experiencing a consultant-led model of care viewed the role differently to those experiencing amidwifery-led model.

Tracey Cooper
Consultant Midwife
Lancashire Teaching Hospitals Trust

Dame Tina Lavender
Consultant Midwife
Professor of Midwifery
University of Manchester

Over time, different patterns of care and a range of lead professionals have influenced care provision in relation to childbirth. The role of the midwife has been influenced by historical factors, research and service changes within the National Health Service (NHS). The medicalisation of childbirth led to a pattern of care that focused on an underpinning principle of ill health rather than focusing on the perspective of normality (Department of Health, 1993; Green et al, 1998), and where the philosophy of a normal birth was only seen in retrospect (Lavender and Walkinshaw, 1998). However, there is now evidence that supports the efficacy and safety of providing care that has a foundation based in a normal model of care (Olsen, 1997; Green et al, 1998; Olsen and Jewell, 2000). Despite this evidence, there is an indication of marked variation in the way maternity care is delivered to women (Foster and Gold, 2002; Hall, 2002). To compound this variation there is a lack of evidence that indicates how women accept these differing models of care (Garcia et al, 1998).

Medicalisation of childbirth has had a considerable influence on the interpretation of normal birth and the role of the midwife. According to Becker and Nachtigall (1992) medicalisation of childbirth can essentially be defined as a process that has resulted in childbirth being regarded as a medical event rather than a social one; an event in which human experiences are redefined as medical problems. Medicalisation is considered the norm when the cultural environment professionals are working in is dominated by intervention, therefore a perception of what normal birth is becomes distorted. Medicalisation of childbirth, combined with modernity (Murphy-Lawless, 1988) and authoritative knowledge (Jordan, 1997), leads to a technocratic model of birth becoming the norm. Birth Choice UK (2011) shows how the caesarean section rates have increased from 12% of births in 1992 to 24.8% in 2010, which has not led to significant improvements to perinatal mortality (The King's Fund, 2008), suggesting that technocratic birth models may have led to this situation. Little is known about how women currently view the midwife's role; one of the few studies that exists reports that women are unaware that midwives have the ability to work autonomously, identify risk and deal with obstetric emergencies (Lavender and Chapple, 2002). Sandall et al (2001) found that women reported high levels of satisfaction with care from a midwife working in a case-loading team. The majority knew their carer through pregnancy, labour, birth and the postnatal period. In Walsh's study (2007) women described how midwives 'got them through' labour. This seemed to be achieved by one-to-one support, rather than 'getting the woman through the process', which is part of the culture of hospital

labour wards. Houghton et al (2008) found that women perceive the use of technology to be an important part of the midwife's role and perceive birth in hospital to be safer than at home or in a freestanding birth centre. In Symon et al's study (2007) women who rated themselves in a risk category of 'none' or 'low' reported that they experienced higher standards of care, greater help and encouragement, and felt more involved with decision-making if their birth experience was in a midwife-led unit than those who experienced birth in a consultant-led environment. Quantitative data showed women experiencing birth in a midwife-led unit had shorter labours and were more likely to experience a normal vaginal birth than those experiencing a consultant-led birth environment. There is an indication that midwives work in different ways depending on the environment that they are practicing in, having different values and beliefs about their role and the way in which they work (Mc Farlane and Downe, 1999; Van der Hulst, 1999; Hunter 2005). Lavender et al (2001, 2002) found that how contemporary midwives view their role suggests that while role extension may increase continuity of carer, it can also devalue midwifery. How midwives view their role may also influence how women view the role of the midwife. Several gaps were identified in the literature, particularly relating to women's perceptions of different models of care and the influence of these on their perceptions of the midwife.

Aims

This study explored how women perceive the midwives' role. In fulfilling this aim, participants were asked the following questions:

- What do women know about the midwives role?
- How do women perceive the midwives' role in relation to that of other health professionals?
- What factors contribute to women's perceptions of the midwives' role?
- Do women's perceptions of the midwives' role influence their choice of birth setting?
- Do women's perceptions of the midwives' role influence their clinical choices?
- What role do women want midwives to play in maternity care?

Method

The literature review identified that women receive care differently within different models of care, led by different professionals; this area requires further exploration. An element that was unclear within the literature was whether perceptions differed, depending on whether or not it was their first maternity experience. A further area that warrants investigation is whether women's role perceptions differ depending on whether they are pregnant or have recently given birth. Focus groups were chosen as a method to provide a baseline of women's perceptions and allow for exploration of the areas identified. Insights into beliefs and attitudes of the underlying behaviour of a specific population can be achieved by using focus groups (Carey, 1994; Asbury, 1995). A purposive sample was chosen to guide the elements discussed from the literature review. This study used a semi-structured interview approach to allow for some flexibility, to protect the participants from disclosing aspects they felt uncomfortable with, but also to allow a change of direction depending on the unfolding discussion within the groups.

Participants

The sample was recruited from a hospital trust in the West Midlands that provides three different birth environments: the woman's home; a midwifery-led unit; and a consultant-led labour ward. Women within the purposive sample were given information leaflets by the community midwives and asked by them if they would like to participate. The community midwives gave contact details of the women who wished to participate, who were then contacted by phone. If they agreed to participate, their name, phone number, parity and lead professional details were recorded; they were placed in the appropriate sample and invited to the group. Three of the focus groups were held at the hospital, one was held at a local health centre.

Data collection

Consent was gained by the hospital trust and from the local research ethics committee for the study to commence. Consent was obtained from participants. A second consent form had to be completed for the use of quotations obtained and used in research reports, as specified by the research ethic's committee. The focus groups were recorded using audiotape. Ground rules around confidentiality and respecting each other's voices and opinions were discussed at the beginning of each focus group. Walsh and Baker (2004) discuss how facilitating focus groups can be a specialised task as some participants' viewpoint and voice can overshadow others. It is therefore important that the group is facilitated fairly, allowing everyone to contribute.

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Table 1. Focus group pseudonyms
Group 1: Louise, Sarah, Liz
• Women who were within 6 weeks of having their baby (postnatal) • Receiving midwifery-led care (MLC) • Gave birth in midwifery-led setting
Group 2: Shona, Carol
• Women in at least their second pregnancy (antenatal/multigravid) • Incidentally receiving consultant-led care (CLC)
Group 3: Susan, Tara
• Women in their first pregnancy (antenatal/primigravid) • Incidentally receiving consultant-led care (CLC)
Group 4: Jane, Debbie
• Women who were within 6 weeks of having their baby (postnatal) • Receiving consultant-led care (CLC) • Gave birth in a consultant-led setting

The interviews were transcribed verbatim. The women were able to withdraw from the study at any time and this would not affect the care they were receiving. Data was kept within a locked cabinet on NHS premises. A semi-structured interview plan was used, which had been agreed by the Ethics' Committee. Field notes were made following the discussions. A reflexive approach was used.

Data analysis

The data recordings were listened to three times by the researchers before transcribing. Computer software was not used, but the data broken down manually, allowing immersion into the data. The transcripts were coded using words that were reoccurring line by line. These were then grouped into themes, repeating the process for each focus group. This experience was extremely valuable, as it gave a sense of knowing the data 'inside out'. Collective analysis of the completed transcripts was then carried out. Multiple analysts were used (Tracey Cooper, Tina Lavender) to prevent interpreter bias. Rigor was maintained by ensuring a clear audit trail, being reflexive and presenting sufficient participant quotes.

Results

For each focus group, ten women declared an interest to participate and were telephoned the day before the focus group to encourage attendance. On contact, it was clear that some women had changed their mind about attending and others failed to attend unexpectedly. The groups were therefore small in size, varying from two to three participants in each. A small group size (two to four participants) allows in-depth data to be collected, if drawn from a purposive sample (Morgan, 2004). It is especially meaningful if the sample is purposive (Morgan, 2004), as the participants may have 'common ground', making it easier to explore certain aspects relating to that particular group of individuals.

Focus groups comprised of four groups: two primigravid women in the antenatal period (20–24 weeks gestation) of pregnancy; two multigravid women in the antenatal period (20–24 weeks gestation) of pregnancy; three women in the postnatal period (6 weeks) who received midwifery-led care and gave birth on the midwife-led unit or at home; and two women in the postnatal period (6 weeks) who received consultant-led care and delivered on central delivery suite (*Table 1*).

While analysing the data it became apparent that women's views reflected two clear viewpoints: women experiencing midwifery-led care; and women experiencing consultant-led care. Group 1 perceived the role of the midwife in a different way to the views expressed in Groups 2, 3 and 4. It was surprising how different the two viewpoints were, therefore the researchers checked and rechecked over the data, to ensure accuracy of analysis. The themes identified were: midwife's influence on women's empowerment; influence of family, friends and media; technology and monitoring; and the influence of doctors. The over-arching theme was that women experiencing midwifery-led care have a different view of the midwife's role compared to women experiencing consultant-led care.

The influence of midwives on women's empowerment

Conceptualisation of empowerment is viewed by the researchers as midwives giving support, reassurance and encouragement which produces self-belief in the women that they 'can get through' labour and 'do it' themselves.

The women were asked what they thought the role of the midwife was:

'She let me take the lead ... She made me believe in myself, that I could do it.' Sarah (Group 1, homebirth)

'She let me basically get on with it. My previous experience (on labour ward) they were sort of like they were in

charge, you just go with what they want you to do. My midwife this time kept saying where do you want it, you can have it anywhere upstairs, downstairs, wherever. She let me be in control. I knew what I had to do and she helped me do it.' Liz (Group 1, homebirth)

The women in Group 1 made their own decisions and managed without pharmacological pain relief. They enjoyed having a known midwife and they all birthed naturally. They viewed birth as a social, rather than a medical event.

This belief in themselves and their bodies seemed to be fed from the midwives. The empowerment women felt seemed to support them achieving a physiological birth. It is presumed that the midwives had a strong belief themselves in the physiological birth process for them to feel confident in their own ability. Conversely, there is no evidence within this study, of women who had experienced consultant-led care being influenced by the midwife in this way.

Women expressed how they befriended the midwife and how this 'connection' assisted them to have faith in their 'body and soul' enabling them to have a positive childbirth experience. This was evident from their body language (for example, emotional, facial expressions) and their narratives:

'She did so much more than I thought, I did feel really close to mine, I got really emotional the last time I saw her.' Sarah (Group 1)

'She was amazing, yes, I couldn't have done it without her, she helped me so much. It was just the way that she was, she made me know that I could do it.' Louise (Group 1, waterbirth on midwife-led unit)

This theme was only identified in Group 1.

The influence of the media, family and friends

The media can be extremely powerful in relation to birth (Betterton, 1996). There are many television programmes, books and magazines containing real life or fictional interpretations of pregnancy, labour and birth; these can influence how women interpret the role of the midwife. Family and friends can equally influence women's perceptions of the midwife's role. The primigravida (primip) antenatal group were influenced by family and through the media:

'I saw a lot of normal births on television; I was expecting to have a normal birth, but the doctor said I would have to see what happens as lots of things can go wrong.' Susan (Group 3)

This shows how the influence of the media can shape a woman's expectations of their forthcoming birth experience. It is positive and encouraging that Susan had seen a lot of normal births on television, but disappointing that the doctor was not supportive and appeared to view birth as being complicated and needing to be controlled; this appeared to change her perspective. Family and friends also influenced women's perceptions of the midwife's role:

'My friends and my family have influenced me the most on what to expect.' Debbie (Group 4)

'My mum and my sister told me what it was going to be like ... you can't read it can you? It's just about how it is, I have taken my sister's advice, I'm going to have an epidural.' Tara (Group 3)

Friends' experiences are likely to be more recent and relate to birth choices offered at the current time. Families' views of birth and the role of the midwife may be influenced by previous experiences and historically how the business of birth was performed at that time. Mothers have anxieties about their daughters becoming a mother themselves and want to advise and protect her within this new experience. Her partner's mother may also feel the same (Marchant, 2004). Therefore first-time mothers have a lot of support and advice, but it may conflict with that given by the midwife. The multigravida (multip), antenatal (A/N) group of women, also experiencing consultant-led care (CLC), were influenced by their previous experiences:

'We have done it all before (childbirth) so it is second nature.' Shona (Group 2)

'Yes, I agree, I know now what they want me to do because of having the other one, I just do what I'm told.' Carol (Group 2)

Shona described her experiences as 'second nature' suggesting that she does not view them as natural. The consultant-led care women seemed

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to have an underlying acceptance of what they were offered:

> ***'I just do what I am told ... It's not worth planning what I want to do, he [consultant] will tell me what he wants and I will do it, because he knows what's best.' Shona (Group 2)***

Shona trusts the doctor to make decisions for her; she does not appear to object to the doctor asserting power and control over her decisions. She accepts that the doctor has the authoritative knowledge. The women who were experiencing birth for the first time sought out some information related to their experience, but they were compliant in accepting the package of care that they were offered, a factor that resonates with earlier studies (Stapleton et al, 2002). One of the women in the antenatal primigravid focus group did research her choice, but unfortunately was not supported or encouraged by the doctor to aim for a normal birth, but informed that something was likely to go wrong in her pregnancy or during labour; this caused unnecessary anxiety. Louise (Group 1) had used magazines and Sarah (Group 1) used television to research their choices. Liz in the same group used books, midwives and friends to research her birth choices:

> ***'In a magazine it said that if you have a homebirth you are less likely to have pain relief and will be more relaxed ... My partner thought I was mad, but it was my choice, my decision.' Louise (Group 1)***

> ***'My midwife has told me so much, but I also found out about pregnancy and birth from my friends who lent me some fabulous books that I found useful.' Liz (Group 1)***

Women experiencing midwifery-led care appeared to research the information they needed to make an informed choice from various sources.

Technology and monitoring: How women perceive what the midwife does

The women receiving midwifery-led care felt that the main role of the midwife was about empowering women to 'get through' the normal physiological birth process. Technology and monitoring were both significant features within the data obtained from women receiving consultant-led care. Monitoring the pregnancy, labour and birth were perceived as the midwife's main role:

> ***'She obviously does the routine blood tests, checks my water, the heartbeat and where the baby is ... She does very close monitoring, I'm very impressed.' Tara (Group 3)***

> ***'They monitor, they tell me what's in my water, what my blood is like and what my blood pressure is and refer to the doctor.' Carol (Group 2)***

The women receiving consultant-led care seemed to view the role of the midwife as performing tasks and using technology. Women appear to get to know about their pregnancy through technological interventions, for example, through ultrasound scans and fetal heart monitors. The women do not seem to view themselves holistically as a whole person, but are disembodied, viewing themselves as different parts needing regulation (Martin, 2001). They view the midwife as knowing her pregnancy through tasks relating to technology and measurement of their body parts. Women receiving consultant-led care defined the midwife as being useful in translating what had been said to them by the doctor and felt that providing a translation of obstetric language was a major part of the midwife's role:

> ***'The midwife seems to put it into better words, so it's not so scary.' Debbie (Group 4)***

> ***'When I went to see the doctor I didn't really understand what he was on about, so I waited until I saw the midwife and she explained to me what he had written in my notes, the words they use I just don't understand it. The midwife made it really easy for me to understand.' Susan (Group 3)***

The women did not question the doctor or ask for a different explanation, they accepted that they needed a translator. Women believed that the doctor had the authoritative knowledge, and therefore did not question the information provided. Women experiencing consultant-led care valued technology, suggesting that technology is progressive:

'She [midwife] uses all the technology that is now available, in the bad old days they did not have scans or monitors.' Carol (Group 2)

'She [midwife] listened to the heartbeat with a machine thing and the scans reassured me that my baby was fine.' Jane (Group 4)

In contrast to this, Sarah, in the midwifery-led care postnatal group, positions herself differently. She suggests that monitoring and technology are a disadvantage to a woman in labour, she describes the care of her friend in labour who was having her baby on the consultant-led care labour ward in the hospital:

'I decided to have a homebirth after seeing my friend in hospital. She had her baby on the main labour ward. The experience made me want a homebirth more ... My friend she was monitored, she went through gas and air, pethidine and could not move off the bed and then had an epidural put in. The midwife told her she was going to perform an internal, but she had also catheterised her. All of these things just led to more and more complicated things, I just thought I don't want all that monitoring and drips and everything I just want to be me and feel in control, as long as I don't have all this, I thought yes, I will be fine at home.' Sarah (Group 1)

Sarah seemed to understand that birth can be free from intervention and related this to being able to stay as 'herself'. Her description of her friend's experience emphasises the importance placed on her personal control. Sarah appeared to view her friend as being disembodied; an experience that she did not want for herself. She viewed her decision for choosing a homebirth as a way of remaining embodied.

Influence of choice of birth setting and clinical choices resulting from perceptions of the role of the midwife

All of the women in the study accepted the care and birth setting they were offered, including the lead care professional they were associated to, except for Sarah. At the outset from her first appointment with the midwife she expressed her preference to have a homebirth with a midwife. She had no risk factors so was booked to birth her baby at home. Her experience of visiting her friend in a consultant-led birth setting, including her view of the actions of the midwife caring for her, influenced her decision-making about her birth setting. Sarah had decided she did not want the clinical intervention she witnessed, therefore her perception of the care the midwife was giving also influenced her clinical choices.

Shona and Carol both appeared to be happy to be categorised by the midwife as requiring consultant-led care and be in a consultant-led birth setting. They were both happy to accept monitoring and intervention by the midwives and doctors without question, as they felt that 'they would do the right thing' for them. Carol requested to change her lead consultant to one she previously received care from, this was not influenced by midwives, but was her own choice.

How women perceive the role of the doctor, in contrast to the role of the midwife

With the exception of the midwifery-led care postnatal group, when asked about what women think a doctor does, all of the women felt that the doctor was the decision-maker and the midwives carried out their instructions:

'I think the midwives need the doctor to make the decisions. The midwife is constantly waiting for the doctor to decide on the results she has.' Susan (Group 3)

'The midwives do the monitoring on a regular basis, but it is definitely the consultant that is the one who makes the decisions.' Shona (Group 2)

The women see the midwife giving the results to the doctor; therefore, she perceives it as the doctor's role to inform her if the pregnancy, labour or birth is progressing normally, not the midwife. The women view the doctor as the powerful decision-maker and the midwife as a handmaiden. The way in which midwives conduct their role leads to women interpreting what they see. The women view the doctor as having the authoritative knowledge (Jordan, 1997), which she has perceived by viewing interactions between midwives and doctors. She interprets this as midwives and doctors supporting the technocratic birth culture, rather than supporting the philosophy of normal birth. One of the most interesting aspects of the

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data collected was from the women receiving consultant-led care regarding their choice of health professional:

> ***'Well I had to have a consultant because of my problems. I am under Mr D, he's had all of mine.' Shona (Group 2)***

This comment is extremely interesting as the doctor could be mistaken for the woman's partner. This may be related to the culture within the institutional environment or perhaps related to the trust she has placed in the doctor. She appears to situate herself as owned by Mr D. This also correlates with Carol's response:

> ***'I've never had a problem with Mr B, I've had three children with him, so if there is not a problem why fix it ... He's never caused any complications. He takes good care and he allows his midwives to take quite a bit of care. He allows them to do all of the monitoring, he will fix me if need be.' Carol (Group 2)***

Carol's comments correspond with Shona's in relation to her identifying her children as Mr B's, placing trust in Mr B to take care of her through this experience. Carol views herself as disembodied; she views Mr B as her body fixer. Carol perceives the midwife as being under the control of Mr B. She perceives the technology used for monitoring by the midwife as the main focus of her role through what she has witnessed. The women experiencing midwifery-led postnatal care were asked what they thought the doctor did, which was in contrast to what has been found above:

> ***'I haven't seen a doctor at all through my pregnancy; I have never felt I have needed to.' Louise (Group 1)***

> ***'The doctor said my baby was breech, I didn't worry, I just asked my midwife to check, she felt it as being head down and she explained what she was feeling where. She was right it was head down.' Sarah (Group 1)***

The midwifery-led women appear to question the doctor's decisions, the need to see a doctor and ownership of their bodies. There appears to be a distinction between how the women experiencing consultant-led care and those receiving midwifery-led care perceive the role of the midwife and childbirth.

Discussion

The aims of the focus group were met in that the findings provided useful insight into the perceptions of women regarding the midwives' role. The empowerment belief of women created by midwives provides a really interesting aspect, which only presented within the views of women experiencing midwifery-led care. Robertson (1994) argues that the all-consuming and overwhelming nature of birth, including the weathering of pain, is an empowering process for women and a process that should not be withheld unless it is detrimental to her or her baby's wellbeing. This study found that midwives influenced women's empowerment of the normal physiological birth process in a midwifery-led model and birth setting. Therefore, this influence is key to engaging women with the normal birth process. The distinction between this occurring within a midwifery-led model compared to the women experiencing a consultant-led model has not been found within any other study. The findings suggest that it is the midwife that has given them the belief in the normal physiological process of birth and empowered them to 'get through' this process. The midwife helped them believe in an embodied process of mind, body and soul. The underlying framework of the midwifery model is the understanding and the value of connection; the understanding of relatedness of the body and mind (Foster et al, 2004). This connection and understanding was apparent in the findings. Anderson (2006) argues that trust can give feelings of safety and relaxation. She discusses the theory of the relationship between trust and oxytocin levels in the body; if trust is there oxytocin levels will increase, which in turn will progress labour, reduce blood pressure, increase blood circulation and increase healing of wounds. Therefore, the underlying principle of empowerment may be 'trust'.

Empowerment may also contribute to significant health benefits for mothers and babies. The midwives who created the belief in empowerment to these women worked within a midwifery-led model, where autonomous practice would exist. Kitzinger (2005) discusses how wherever autonomous midwifery exists perinatal mortality rates are at their lowest. These factors may only be able to flourish in a midwifery-led setting, due to the lack of influence from the authoritative knowledge

from doctors and the technocratic medicalised birth culture, even though it would be beneficial for this to be accessed by all women.

The influence of the midwife's role in the media appeared to be strong. The women who experienced midwifery-led care were also influenced by friends. Women who experienced consultant-led care were influenced by their family or previous childbirth experiences; if it was their first baby they were also influenced by the stories and imagery seen in the media. Existing research on the influence of women's perceptions of childbirth includes Betterton (1996), Martin (2001), Kitzinger (2005) and Kingdon (2009). Clement (1997) and Garrod (2012) discuss how the power of television particularly shapes the view of contemporary British women concerning the risks, pain and inconveniences associated with childbirth. Women experiencing consultant-led care observed the midwife within a consultant-led environment and viewed their role to be central around their close relationship with technology and monitoring. Houghton et al (2008) found that women viewed using technology as an important part of their role. This study also builds on this knowledge. Sinclair (1999) identified that technology did not undermine the midwife's position, but instead appeared to focus and strengthen it. Following this study, further work needs to be done to investigate further. This was in contrast to the midwife's influence on women's empowerment, which was found within the perceptions of the women observing midwives in a midwifery-led environment.

The women's views of the doctor's role in relation to the role of the midwife revealed differences in the perceptions of women experiencing care led by different health-care professionals. The women experiencing consultant-led care perceived that the doctor is the decision-maker within the relationship with her and the midwife. She views herself as unrelated at times to her body, disembodied. She sees the midwife as a handmaiden to the doctor, who uses technology to test her body and then reports the results to the doctor who makes the decisions about what interventions are needed to ensure her body functions in a timely manner. The rise of faith within science and technology has led women, midwives and doctors to trusting the machines rather than the woman's reported experience of their own observations (Beech and Phipps, 2004). This has led to widespread routine application of obstetrical technology at hospital births. The route to this problem lies in the hierarchical position of the doctor over the midwife, which is based on control of obstetrical technology and the dominance of the obstetric model over the midwifery model, which remains the basis of authoritative knowledge (Fiedler, 1997).

“The women's views of the doctor's role in relation to the role of the midwife revealed differences in the perceptions of women experiencing care led by different health-care professionals”

Midwives may be unaware of how they project their role, unaware that their own actions and interactions with colleagues are observed and interpreted by those they are caring for. Lavender and Chapple (2002) discussed that their study suggested there were two types of midwives, but were unable to delve any deeper; this study adds further evidence to this assertion. Hunter's (2005) findings where midwives working in community-based teams were identified as working in a 'with women' model practised in an individualised holistic view of women and met their individual needs, which is similar to the women experiencing midwifery-led care perceptions of the role of the midwife. The participants of the study working within the hospital worked with an institutional approach to birth, these midwives are described as 'with institution' midwives. This way of practising corresponds with the women's views of the midwife's role if they experienced consultant-led care and birth setting. When McFarlane and Downe (1999) assessed midwives training needs they too found two completely different concepts of midwifery depending on if they worked in the community or hospital, which correlates with Hunter's (2005) study. It also resonates with women's view of the midwife's role in this study, depending on the model and birth setting they experienced. It may be of benefit to compare both women and midwives perceptions of the role of the midwife.

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Key points

- Technology and monitoring was interpreted as an essential part of the role of the midwife by women experiencing consultant-led care and birth setting
- There is an assertion that there may be two different types of midwives, as the role was perceived differently by women depending on the lead professional and appropriated care and birth setting
- Doctors were perceived as having authoritative knowledge by women experiencing consultant-led care and birth setting
- Interpretations of childbirth and what the role of the midwife entails in the media influenced all women in the study
- The most original finding of this study was the empowerment belief instilled by the midwife about the normal birth process, which inspired women to believe in their bodies to 'give birth' when women experienced midwifery-led care and birth setting

Future research investigating midwives' perceptions of their role is necessary. The women experiencing consultant-led care provide compelling aspects, which need to be explored further to ascertain an in-depth view of how they perceive the role of the midwife. There has been an increasing body of evidence created of women experiencing midwifery-led care (Flint et al, 1989; Page, 1999; Sandall et al, 2001; Walsh, 2007). Views from women experiencing consultant-led care are not frequently investigated in comparison.

Strengths and limitations of the study

The strengths of the study were that further knowledge on five key findings was found. This included original knowledge about an empowerment belief instilled in women by midwives working in a midwifery-led model of care about the normal birth process. They also inspired women to believe in their bodies to 'give birth' when women experienced midwifery-led care and gave birth in a midwifery-led setting.

The numbers in the focus groups were small, although this did allow for deeper investigation and of certain aspects discovered. Holding the focus groups in children's centres, may have assisted in a higher attendance, as many women meet here for different groups set up for antenatal women and parents with babies. Other aspects from a larger group may have given different perspectives and may have provided more varied data. The participants were recruited from one hospital trust, therefore the findings may not be consistent with other areas of the country. BJM

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provide them with the expected and needed care during labour. Some women view midwives as friends, with the relationship characterised by mutuality and intimacy (Nicholls & Webb 2006:415).

According to the Scottish Government Department of Health, Social Services and Public Safety (2010:22), midwives play a central role in ensuring that women have a safe and life-enhancing experience based on their expectations during their maternity care and that their babies and families have the best possible start in life. Midwives are autonomous professionals whose unique and specialist contribution affects the whole population: each of us at the time of birth, the great majority of people who become parents and the half of these who become mothers. Women and their families expect a service that provides clear communication and explanations, effective teamwork, a safe, caring environment and continuity of care. A midwife's role is to ensure that these expectations are understood and met (Scottish Government Department of Health, Social Services and Public Safety 2010:22).

There is growing awareness that a person's individual beliefs, expectations, attitudes, perceptions and thoughts not only have an influence on how mothers feel and behave but directly influence the reality they experience (Fenwick *et al.* 2005:30).

The lack of a birth plan, a communication document that is uniquely designed according to the mother's needs and expectations, may lead to unfulfilling experiences (Fraser, Cooper & Nolte 2010:451). These authors echo Maputle and Nolte's (2008:5) view that midwives' inability to give information and clear explanations to mothers during labour may lead to feelings of disappointment which may later generate negative experiences. If mothers are not given adequate information, they may not be able to communicate with their physicians and midwives or be willing or able to ask questions (Hunter 2006:320). Not allowing the fathers or partners to provide support to the mothers during labour may prevent bonding from occurring between them and the baby. According to Lowdermilk and Perry (2006:426), fathers are valuable in providing support, encouragement and reassurance to the mothers during labour.

This article explores and describes mothers' expectations of midwives' care during labour. Face-to-face, in-depth individual interviews were conducted to investigate mothers' expectations of midwives' care during labour.

Problem statement

Hunter (2006:310) states that a woman–midwife relationship should be a partnership based on equality, shared responsibility, empowerment, continuity of care giving, individual negotiation and informed choice and consent. Henderson and Macdonald (2004:433) agree with this view by stating that the relationship between the mother and the midwife is ideally a partnership ethos requiring the involvement of the mother and her partner in decision making whereby the mother is able to voice her needs, expectations and wishes freely. They further indicate that the midwife should strive to build a relationship of mutual trust and create an environment in which expectations, wishes, fears and anxieties can be discussed, based on good communication resulting from a two-way interaction between equals.

Barker *et al.* (2005:315) reported accounts of mothers feelings of little control that were related to inadequate information provision, poor communication and lack of opportunity to influence decision making, including negative attitudes and behaviours of maternity staff that were linked to mothers' negative feelings such as fear, anger, disappointment, stress, guilt and inadequacy.

Mothers going through labour and childbirth must receive individualised holistic care to meet their unique needs and expectations because they experience stress and physical pain, hence, midwives as skilled attendants should provide an environment which allows mothers to go through childbirth with dignity by providing adequate and relevant information that allows the mother to make relevant informed decisions (WHO 2003: 35).

According to Maputle and Nolte (2008:56), once mothers seek midwifery care during childbirth, they are expected to follow set standards, midwifery protocols and procedures that do not always manifest the experiences, needs, expectations and priorities of mothers during childbirth. Furthermore, Modiba (2012:19) explains that where care is appropriately organized, and midwives hold interpersonal, clinical skills and knowledge, care is more likely to be positive. If care is fragmented, oriented to technology, protocols and standards rather than human relationship, where midwives do not have professional autonomy and the culture of care is institutionalized, even if they hold the best skills, attitudes and knowledge, the midwives will not be able to do their best in support of the mothers and their families.

From the above stated problem statement the following research question arose: what are the mothers' expectations of midwives care during labour?

Purpose and objective of the study

The purpose of the study was to determine mothers' expectations of midwives' care during labour in a public hospital in Gauteng.

To achieve this purpose, the researcher sought to explore and describe mothers' expectations of midwives' care during labour.

Significance of the study

This study may ensure that, in order to improve practice, midwives' care must be based on evidence of what mothers expect of midwives care during labour. The study may

inform midwives' care that could be rendered to the pregnant mothers during labour. Provision of care to be rendered may be individualised, based on mothers' expectations; thus enhancing the quality of care that is rendered to mothers during labour.

Paradigmatic perspective

The study focused on the promotion of health of the individual, family, group and community, using the Theory for Health Promotion in Nursing (THPN) (University of Johannesburg 2006:2). This theory is specifically applicable in the realm of midwifery practice as the mother is viewed holistically in interaction with her environment. The midwife as a sensitive, therapeutic professional facilitates the promotion of health through the mobilisation of resources. The meta-theoretical assumptions of the THPN (University of Johannesburg 2006:2) are:

- unconditional acceptance of people and respect for human rights;
- sensitivity towards cultures through empathy and caring;
- realizing and facilitating virtues such as honesty, commitment, trustworthiness, acceptance of responsibility and accountability, courage and perseverance, and promoting co-operation and empowerment by being consumer friendly and helpful through availability and accessibility.

Operational definitions

For the purpose of this study, the following concepts were used as defined below:

- Mother refers to a female parent of a child or offspring (Allen 2006:903). The mother in this study refers to a pregnant individual who was in labour at a specific hospital in the Gauteng province.
- Expectation refers to the hopeful anticipation of a desired event (Allen 2006:487). In this study expectation referred to the mothers' anticipation of midwives' care during labour.
- Midwife refers to a person who has been admitted to a midwifery educational programme, duly recognised in the country in which it is located, who has successfully completed the prescribed course of studies in midwifery, and who has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery (International Confederation of Midwives' Council Meeting 2005:1).
- Care refers to those assistive, supportive, helping, facilitated, professional, moral and culturally accepted actions rendered to the individual, family or group, whilst feeling concern or interest, providing protection and showing attention to the one being cared for; through a competent and interactive therapeutic caring relationship (Msolomba 2007:207).
- Labour refers to the act of giving birth to a child. It is characterised by regular and rhythmic uterine contractions and the gradual dilatation and effacement of the cervix. The first stage lasts until there is full dilatation of the cervical os, the second stage lasts until the baby has been delivered and the third stage implies the delivery of the placenta and membranes (Brooker 2006:136). The fourth stage refers to the period after delivery of the placenta up to one hour post-delivery (Dippenaar & Da Serra 2012:316) In this study labour occurred when the mother had reached term, that is 36–40 weeks of pregnancy, and commenced when the cervix was 3 cm dilated until 10 cm dilatation; it included the first, second and third stages up to the end of the fourth stage of labour.

Research approach and methods

The study was quantitative, explorative, descriptive and contextual in nature. A qualitative approach was used in order to gain insight into mothers' expectations of midwives care during labour through discovering meanings they attach to these expectations (Burns & Grove 2005:52). The study was also contextual since validity of the findings is claimed only in the labour ward of a specific public hospital in Gauteng where the study was conducted (Minnie, Klopper & Van der Walt 2008:52).

Setting

The study was conducted at a specific public hospital based in the Gauteng province. This is a third level academic hospital that provides specialised service to a semi-rural nearby community. It also serves as a referral hospital for other level one hospitals and clinics that are nearby.

Study population

Polit and Beck (2012:738) define a research population as an aggregate of all the individuals or objects to be studied with some common defining characteristics. In this study the population entailed all mothers' who delivered in the labour ward under the care of midwives and were then transferred to the postnatal ward of a specific public hospital in Gauteng. The mothers were recruited from the postnatal ward because for the first two hours after delivery (fourth stage of labour) they need adequate rest and time to bond with their new born babies. The mothers also need to be closely observed by midwives (to exclude complications such as postpartum bleeding). Those who agreed to participate were willing to be interviewed on day one of their postnatal period (the day following delivery). This date was convenient for the mothers because those who deliver normally without any complications are usually discharged on day one or two following their delivery day.

Sampling

Purposive sampling was used to ensure that a specific representation of the entire population was selected (Polit & Beck 2008:338). No predetermined number of participants was specified. In order to be included in the study, the mothers could be of any age and the pregnancy must have reached term; the mothers must have been observed for more than four hours in the labour ward because this would give

adequate time to experience care provided by the midwives. For ethical reasons of not inducing further trauma through the interviews, only mothers who had delivered normally and their babies were alive were included. Mothers must have given informed consent to participate in the study.

Pilot study

De Vos *et al.* (2011:237) define a pilot study as a procedure for testing and validating an instrument by administering it to a small group of participants from the intended test population. Two face-to-face, in-depth individual interviews were held with mothers who were chosen from the population, but were not included in the main study. The researcher conducted a pilot study to determine whether the central question and the instrument used elicited the information being sought. The results yielded the intended information; hence the central question was not changed. The findings from the pilot study were not included in the main findings.

Data collection

Data was collected in a suitable environment for the mother identified by the hospital management whilst babies were cared for in the nursery. Face-to-face, in-depth individual interviews were conducted in English because all the participants were able and willing to speak English and one central question was asked:

> Please tell me, in detail, what are your expectations of midwives' care during labour?

A tape recorder was placed strategically to capture dialogue between researcher (moderator) and the participants. Each interview lasted for 45 min to 1 h.

The researcher conducted follow-up interviews with the mothers during their six week postnatal visit to verify whether the results were a true reflection of their verbalised expectations.

Data analysis

Data analysis was done by the researcher concurrently with data collection using Tesch's eight steps (Creswell 2009:186). Data was collected until no new data emerged and saturation was reached. The data was also analysed by an independent coder, who then met with the researcher to discuss and reach consensus on the identified categories and subcategories.

Trustworthiness

Lincoln and Guba's model (De Vos *et al*. 2007:345–347) was used to maintain trustworthiness of the study. The following criteria for trustworthiness were applied in this study: credibility, transferability, consistency, neutrality.

Credibility was enhanced by implementation of the following strategies:

- Member checking. Follow-up interviews were held with the participants for validation of the data.
- Peer examination. The study was supervised by an expert in research methods and midwifery. The data was also analysed by an independent coder experienced in qualitative research methods and midwifery.

Transferability was enhanced by giving a thick description whereby the researcher gave in-depth discussion of the research methodology and the findings.

Consistency was ensured by using a peer examination strategy, as well as by doing stepwise replication in which the researcher was under the guidance and supervision of the mentor throughout the study.

A dependability audit was ensured by the involvement of an experienced researcher (supervisor) in qualitative methods, who followed the progression of the study to analyse and evaluate decisions made, as well as to determine whether comparable conclusions could be reached given the same data and research context.

The researcher's authority was established by analysing the characteristics that enabled her to conduct the research efficiently. The researcher has a master's and doctoral degree in Midwifery and Neonatal Nursing, has developed investigative skills, literature review experience and interviewing skills as well as experience in qualitative research methods.

Neutrality entails freedom from bias in the research procedure and findings. It also refers to the degree to which the findings are the product of the focus of the inquiry and not of the biases of the researcher (Babbie & Mouton 2011:278). The researcher held discussions on the collected data with the participants. In some stages of the research project, discussions were also held with the supervisor and an independent coder. The researcher made use of reflective thinking by putting aside her own speculations, feelings, problems, ideas, prejudices and impressions when analysing the data.

Ethical considerations

Permission to conduct the study was obtained from the Research Ethics Committee at the University of Johannesburg Faculty of Education and Nursing Science and the management of the hospital where the study was conducted. Informed consent was obtained from the participants before data collection commenced but first the researcher explained the purpose and objectives of the study in detail. The participants were informed that they could withdraw from the study at any time without fear of being victimised. Confidentiality was maintained throughout the study by not attaching names to the collected data but using codes. The participants were also assured that the tapes that contained the interview information would be erased after transcription of the interviews. The researcher treated the participants with respect by asking questions about their personal views sensitively and they were assured that they would not be exposed to harm or exploitation (Polit & Hungler 2001:76). The participants were informed that

they would not be remunerated for participating and that the results of the study may be published. The researcher provided the participants with her contact details should they have any questions about the study.

Findings and discussion

Discussion of the findings includes responses from the mothers in the study. Tesch's eight steps (Creswell 2009:186) were used to identify categories that were named according to the most descriptive word for that category. These categories were then positioned within the universal categories of THPN (University of Johannesburg 2009:2–13), which was used as a theoretical framework to guide this study that comprises body, mind and spirit.

Body

Regarding the participants' physical well-being, the participants indicated that they desired comfort and a pleasant environment. During admission there was a need for the midwives to give the mothers prompt attention, welcome them warmly and orientate them to the labour ward. Midwives were required to show them a bed to lie on or offer them a chair to sit on before asking them questions and examining them physically. Two of the participants said:

> 'Firstly, I would expect them to welcome me with a smile and ask me what I am there for and what my problems are.' (Participant 4, mother, teacher, 27 years)

> 'I expect basic things, like to be shown around … especially regarding things that I would use in the ward, where to look for help; that is, the basic orientation for starters'(Participant 5, mother, dressmaker, 33 years)

Dippenaar and Da Serra (2012:334) justify the mothers' expectations by stating that the midwife should welcome the mother and give her a brief explanation of the activities which will take place to confirm whether she is in labour or not. They also point out that the mother should be seated in a comfortable chair, but if she is experiencing severe labour pains it may be necessary for her to lie on the admission couch. Privacy must be maintained all the time.

Littleton and Engebretson (2005:507) concur with the mothers' expectations by stating that the midwife should introduce herself, ask the names of the mother and those accompanying her, and accompany them to the admission room. As the midwife helps the mother undress and get into a hospital gown, she also begins to develop rapport and establish the midwifery database. In referring to the mothers' expectations, Leifer (2005:99) agrees that the mother should be made comfortable, and recommends that if she wants to rest in bed, a side-lying or semi-fowler's position rather than a supine position is most comfortable and avoids supine hypotensive syndrome.

Fraser *et al.* (2006:424) explain that the initial examination of the mother should be preceded by taking history regarding her labour, including when labour started, whether the membranes had ruptured and the frequency and strength of contractions. Her temperature and pulse must also be monitored.

The participants expected the midwives to do a needs assessment based on the mothers' emotional status, social problems, knowledge about labour and perception of pregnancy. In reporting on the assessment of the mother during labour, Dippenaar and Da Serra (2012:218) state that monitoring the progress of labour requires more than assessment of the cervical dilatation and uterine contractions. Midwives should give weight to other skills such as abdominal palpation and knowledge of women's changing behaviour. Fraser *et al.* (2006:434) agree with the mothers' expectations by stating that the midwife has a traditional and professional role to fulfil: of clinical assessment of the progress of labour and the physical status of the mother and baby.

During the first stage, the participants expected midwives to provide them with comforting measures such as rubbing their backs and abdomens, assisting them to assume a comfortable position, giving them pain relieving medications, holding their hands, offering them something to drink and then preparing them for delivery. Two of the participants commented as follows:

> 'I want to say that massage does help there. I think if there is somebody there just to rub your tummy or back or even touch you that would ease off the strength of the pain.' (Participant 4, mother, teacher, 27 years).

> I would expect the midwife to assist me in whatever way to endure this pain and if possible, let them give me a pain relieving injection (Participant 2, mother, cashier, 28 years).

Adams and Bianchi (2008:109) emphasise that touch conveys an attitude of caring and encourages comfort. However, a pat on the hand or shoulder may be acceptable to some but not to others. Nurses must consider the client's personal space and cultural background when determining appropriate touch during labour. Holding the mother's hand, stroking her hair or similar actions convey caring, comfort, affirmation, and reassurance at this vulnerable time. Adams and Bianchi (2008:109) also endorse the expectations of mothers in this study by stating that massage, as a form of touch, relaxes muscles and increases blood flow and enhances the release of endorphins, promoting comfort whilst decreasing pain. The Multicultural Perinatal Network (2007:1) contends that massage can be soothing and relaxing to the back, shoulders and legs. They also recommend that a body lotion may be used for massaging the mother.

Romano and Lothian (2008:100) point out that maternal positions that are consistent with the anatomic principles (such as squatting or kneeling positions to enlarge the pelvis) are generally safe and acceptable to women. This idea is supported by the Multicultural Perinatal Network (2007:1), who report that the mother may experience less pain in some positions than in others during labour. Labouring women tend to find upright positions, such as sitting, standing and walking, most comfortable. Many choose a lying down

position as labour advances. Moving about during labour is usually more comfortable than staying still and helps labour to progress as a result of gravity and the changing shape of the pelvis. The Public Health Agency of Canada (2000:7) indicates that a policy of encouraging mobility, particularly in early labour, can potentially facilitate the progress of labour and increase comfort.

Romano and Lothian (2008:98) support the mothers' expectations by stating that eating and drinking during labour provides essential nutrition and energy for the labouring woman. Labour is hard, active work that requires calories, not just hydration. In addition, labouring women preferred to eat and drink rather than fast. The Public Health Agency of Canada (2000: 15) agrees with this view by stating that although the practice of withholding food and fluid once labour has begun exists in many settings, it has become a concern. This practice is not supported in the literature partly because all labours are unique. Thus decisions must be made on an individual basis.

During the second stage of labour, the participants expected the midwives to assist them by holding their legs so as to alleviate cramps and to cut episiotomies professionally. One participant made the following comment:

> 'Maybe say, for instance you are cut in your private part or a stitch, I think it must be done professionally, so that I must not suffer the pain later after giving birth whilst I am at home.' (Participant 1, mother, student, 23 years)

Henderson and Macdonald (2004:497) point out that it is not uncommon for the woman to complain of leg cramps, particularly if she is tensing her muscles during bearing down efforts and utilising the common practice of pulling her knees to her chest. This may be relieved by massage and by extending the leg and dorsiflexing the foot – that is, bending it upwards.

With regard to comfort during the third and fourth stages, the participants expressed the desire to be stitched professionally and to be given a bath and treatment for cleaning the wound. They expected the midwives to place extra pillows at their backs to facilitate good rest:

> 'I mean, washing me, dressing me up and giving me some hot tea or soup then putting me into a comfortable bed…' (Participant 3, mother, housewife, 31 years)

> 'They must constantly check on me, in terms of my physical condition.' (Participan 1, mother, student, 23 years)

Fraser *et al.* (2006:487) state that midwives who have had instruction and have had supervised practice in suturing the perineum and are judged to be proficient may carry out the procedure in the case of an episiotomy or second-degree tear. It is kind to the mother to complete this aspect of care without undue delay and whilst the tissues are still anaesthetised. Similarly, the Scottish Government Public Health Agency of Canada (2000:12) argues that the practice of routine episiotomy should be abandoned. Olds *et al.* (2004:1026) explain that the midwife should teach the mother how to care for the episiotomy, since this promotes healing and reduces the incidence of infection.

Johnson and Boyd-Davis (2003:615) state that after giving birth, the woman should be covered with a warm blanket, offered a warm drink if she is not nauseated from an analgesic, and assured that the occurrence is normal. This is usually enough to make the chills transient and will allow her to fall into a sound, much-needed sleep. Most women will then sleep for at least an hour.

Most mothers appreciate being able either to wash or shower at this stage, which can do much to restore comfort and increase a sense of well-being (Fraser *et al.* 2010:466). These authors also suggest that simple comfort measures such as mothers will appreciate are being able to brush their teeth and apply lip balm or cream to alleviate dry mouth and sore lips, especially if inhalational analgesia has been used during labour. There is no evidence to suggest that restriction of food or fluids is necessary, thus a meal and fluids can be offered while the midwife completes her task, and the mother and her support person enjoy a little privacy with the new family member. De Kock and Van der Walt (2004:14–10) emphasise that the first hour after birth is a potentially dangerous period because of the possibility of haemorrhage. Continuous assessment of the uterus should be made to ensure that the uterus stays firmly contracted. If the uterus is boggy (atonic), the fundus should be massaged until it is firmly contracted.

Mind

In terms of the mind, the participants expected the midwives to support them by showing increased sensitivity, that is, not being harsh with them but rather consoling them. The participants' wished for the constant presence of the midwife. They expected the midwives to show interest, concern, advocacy, sympathy and empathy, and to give them emotional and moral support:

> 'They should not be harsh with me.' (Participant 5, mother, dressmaker, 33 years)

In the study, the participants confirmed what D'Ambruoso *et al*. (2005:7) have emphasised, namely that women expect attending midwives to provide guidance and counselling. However, they indicated that providers expect women to know what to do at various stages during labour and delivery and that their lack of knowledge drew reprimands from some attending nurses and midwives. Some of the participants indicated that the nurses and midwives had shown a poor attitude towards them. Their behaviour had included rudeness, undeserved or inappropriate reprimands, shouting at women who were in labour, a lack of sympathy and empathy, refusal to assist, refusal to allow women in labour to touch or hold a midwife, threatening the women with poor outcomes if they did not comply with instructions, denying them service and showing a lack of moral support and encouragement.

Similarly, Maputle and Nolte (2004:83) reported in their study that some mother participants had a firm conviction that midwives lacked comforting measures and emotional support skills. The mothers indicated that midwives had no

sympathy and were unfriendly and that some scolded the mothers.

In discussing mothers' expectations, Kneisl and Trigoboff (2009:37) maintain that genuine interest and concern provide the basis for a therapeutic alliance. The nurse conveys general interest and concern by trying to understand the client's perspective, working with the client on mutually formulated goals, and persisting even when breakthroughs and improvements are subtle and slow instead of dramatic and quick.

Fraser *et al.* (2006:434) explain that emotional support is provided by exercising skill in imparting confidence, expressing caring and dependability as well as being an advocate for the childbearing woman if needed. The midwife should display a tolerant non-judgmental attitude, ensuring that the mother is accepted, whatever her reactions to labour may be. Similarly Kneisl and Trigoboff (2009:39) state that successful advocacy is a positive experience for nurses as well as for clients. Clients derive benefit, and nurses feel good about their ability to be agents of change. The mothers who participated in the study also expressed these views.

Nicholls and Webb (2006:424) support Hunter's (2002:660) standpoint that nurses' presence includes portraying a high level of nursing skill, being open, honest, and non-judgmental with the client, listening intently to her needs and concerns, understanding the privilege of being part of the client's life, and the client's perception of the meaningfulness of the relationship with the nurse. They argue that being there for the woman and having good communication skills are the most important aspects of good midwifery care (Nicholls & Webb 2006:424).

The participants emphasised the need for communication. They expected the midwives to explain their actions and findings, and to guide and encourage them on what to do, without shouting at them but reassuring them throughout labour:

> 'They should explain to you in simple terms because sometimes they say 'push' and you don't know what you are doing, and they shout at you meanwhile you don't understand what 'pushing' is all about. So 'pushing' should be taught and clearly explained so that nothing goes wrong during the delivery.' (Participant 1, mother, student, 23 years)

In articulating their expectations, the participants were in agreement with Lowdermilk and Perry's (2006:426) claim that the midwife can alleviate a woman's anxiety by explaining unfamiliar terms, providing information and explanations without her having to ask, and preparing her for procedures that will follow. The midwife can provide support to the mother by helping her maintain control and participate to the extent she wishes in the birth of her infant and by acknowledging the mother's efforts, as well as those of her partner, during labour and providing positive reinforcement. This idea is supported by Fraser *et al.* (2006:435), who contend that midwives must provide support by giving information that ensures the mother understands events, feels free to ask questions and is aware of how labour is progressing.

Littleton and Engebretson (2005:541) explain that it is important for support persons to help the mother cope by assuring the mother that all is going well, staying with her, and coaching, guiding, encouraging and reassuring her as required throughout the process of labour. The mother needs constant support during labour.

The mothers who participated in the study said that they wished to be congratulated on the birth of the baby. They expected the midwives to instruct them on child care and do follow-up visits in the postnatal ward. One participant said:

> 'I expected them to continue as we started, to congratulate me for being brave and for giving birth to a healthy child.' (Participant, mother, cashier, 28 years)

Fraser *et al.* (2006:434) assert that the support person must ensure that the mother understands every procedure and the results of every examination, that she is informed on the progress of her labour, and that she is praised for her efforts and encouraged to continue.

Parent-newborn attachment is promoted by encouraging the family to be involved with the newborn, such as holding, feeding, and changing its napkins (Leifer 2005:161). Nearly every contact the nurse has with the parents presents an opportunity for teaching that can facilitate their competence in newborn care. The midwife should demonstrate procedures such as baby bathing and cord care to the parents. The mother should be assisted to latch the baby on the breast, especially if she is a primigravida.

The participants expressed a need for the nursing profession to be transformed:

> 'We need an overhaul of the nursing profession. The fact that you are … assisting someone to give birth to a child, do the job just like it's a calling, not like somebody has forced you to do that. Look well after the mother.' (Participant 5, mother, dressmaker, 33 years)

According to the Scottish Government Department of Health, Social Services and Public Safety (2010:33), midwives need to reclaim the core values of their profession and promote these with professional pride to lift the overall public perceptions of midwifery. This concurs with the views expressed by the participants in the study.

Spirit

In terms of the spirit, the participants expressed the following expectations:

> 'Allowing my husband to support me physically and emotionally is the best thing that could happen to me.' (Participant 4, mother, teacher, 27 years)

> 'They must bring my baby before I go to the other ward. I want to see it, cuddle it, and love it because I want to see my flesh and blood immediately and really feel that this is my baby.' (Participant 2, mother, cashier, 28 years)

Lowdermilk and Perry (2006:428) point out that although a man other than the father may be the woman's partner, the father of the baby is usually the support person during

labour. Often, he is able to provide the comfort measures and touch that the labouring woman needs. In addition, he is usually able to interpret the woman's needs and desires for staff members.

Basavanthappa (2006:329) agrees with this view by stating that the father's presence at the birth can be a profound experience for the new parents and make them aware of parenthood as a mutually shared effort. The father's encouragement to sustain the pushing efforts is important. The partner remains at the mother's side, speaking directly into her ear, if needed. He will coach the mother to perform pushing techniques and praise her for her efforts.

Luxner (2005:92) recommends that parents should be provided with an opportunity to see and touch the baby immediately after birth. If the baby needs resuscitation, parents should be allowed to see and touch the baby before it is transferred to the nursery.

According to Romano and Lothian (2008:100), newborns held skin-to-skin by their mothers cry less and stay warmer than newborns placed in warming cribs. Skin-to-skin contact also exposes babies to their mother's normal bacteria, not the hospital germs, which lowers their risk of acquiring infections.

The mothers expected the midwives to respect their cultural and religious beliefs. Their views echo Basavanthappa's (2006:313) standpoint that midwives should know and understand how culture mediates pain because they regularly care for mothers from a variety of cultural backgrounds. In similar vein, Kneisl and Trigoboff (2009:33) state that nurses are better able to meet their clients' socio-cultural needs when they acknowledge that culture and society influence their beliefs, values, attitudes and behaviour.

Conclusion and recommendations

In this study, the mothers' expectations were based on practical issues that are of interest in the maternity health care services. Some of the mothers' expectations in this study were not supported by findings from other studies conducted. All the literature sources used in this study were based on the mothers' expectations during labour and not on midwives' care. For example, in this study, the mothers expected the midwives to give them prompt attention, welcome them warmly, show them the bed, or offer them a chair before asking them questions and examining them physically. The participants also expressed a need for the nursing profession to be transformed. The study was aimed at determining mothers' expectations of midwives' care during labour as these expectations are central to the provision of quality holistic care by midwives.

The findings of the study have shown that the mothers' expectations of midwives' care during labour are for the provision of physical comfort, emotional support, clear communication including good interpersonal skills, and encouragement of bonding between the mother, father and baby. The findings of this study confirm previous findings and contribute additional evidence that massage as a form of touch promotes physical comfort and that labouring women tend to find upright positions such as sitting, standing and walking most comfortable. Regarding the provision of emotional support, it was also found that being there for the mother and having good communication and interpersonal skills are the most important aspects of quality midwifery care. The findings of this study endorse previous studies and contribute evidence regarding bonding between mother, father and baby. It was also found that the father's presence at the birth can be a profound experience for the new parents and makes them aware of parenthood as a mutually shared effort and that newborns that are held skin-to-skin by their mothers cry less and stay warmer than newborns placed in warming cribs.

Based on the information provided above, the researcher recommends that midwives should attend interpersonal skills workshops to enhance their communication skills with the mother and father or partner if he is available. The father or partner should be allowed in the labour ward and encouraged to provide comfort and support to the mother. It is further recommended that midwives should attend training regarding the 'Baby Friendly Hospital Initiative' that encourages bonding between the mother and baby immediately after delivery by implementing skin-to-skin attachment and early breastfeeding.

One of the limitations of the study was the small sample size. Furthermore, the results cannot be generalised since the study was contextual in nature, only individual interviews were conducted and the study was only conducted amongst one racial group.

When the midwives' care includes the mothers' expectations, quality holistic care is facilitated and the mothers' wait in anticipation for nine months is rewarded by positive experiences of her labour.

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Competing interests

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Author's contributions

M.S. (University of Limpopo) conducted the research, and drafted and revised the manuscript.

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Women's experiences of care during labour in a midwifery-led unit in the Republic of Ireland

Abstract

The first two midwifery-led units (MLUs) in the Republic of Ireland were opened in July 2004 in the north east of the country. This study explores women's experiences of a midwifery-led model of care during labour in a midwifery-led unit in the Republic of Ireland. Methods: A descriptive qualitative research study (Sandelowski, 2000) using an interpretive phenomenological analysis and Colaizzi's (1978) process of phenomenological data analysis was used to explore and interpret women's experiences of a midwifery-led model of care during labour in an MLU in the Republic of Ireland. Individual in-depth semi-structured interviews were undertaken with eight women who had given birth in the unit. The interviews were transcribed verbatim. Findings: The themes that emerged were condensed and the findings focused on two categories: homely atmosphere and woman in control. Within the homely atmosphere, the women felt at ease in the MLU and were able to relax, which encouraged them to labour in their own time in their own way. Women felt in control of both the pain of their labour and in their ability to make decisions as they were encouraged to make choices throughout their labour, which served to empower them and provided them with a positive birthing experience. Conclusion: This research study provides a revealing insight into the components of midwifery-led care that are essential to women accessing this model. This includes them having the freedom to do their own thing, progressing their labour in their own way, and receiving support and assistance when requested from a supportive midwife. All of the women reported a thoroughly positive experience of giving birth in the MLU. These components of midwifery-led care could possibly be transferred to other models of maternity care provided the women were in the low-risk category.

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Women's experiences of giving birth provide crucial information for midwives. The quality of the care that has been provided can impact on the woman's experience, which can have a profound influence on their lives (Larkin et al, 2011). The majority of maternity care in Ireland is provided in the hospital setting with the consultant obstetrician as the lead professional responsible for the care of all women, irrespective of risk status (Begley and Devane, 2003). The establishment of the first two, and only, midwifery-led units (MLUs) in the north east of the country has shifted some of the provision of maternity care to smaller units, where the care is provided by midwives and the women accessing that care are in the low-risk category.

There are remarkably few published studies available in Ireland on women's experiences of childbirth; however, those that exist include O'Connor (1995), Larkin et al (2011), Begley et al (2011) and O'Hare and Fallon (2011). There is a distinct gap in Irish literature on women's experiences of childbirth and, in particular, midwifery-led care as it is a relatively new model of maternity care in Ireland.

Midwifery-led care has been defined as care where midwives are:

> ***'In partnership with the woman, the lead professional with responsibility for assessment of her needs, planning her care, referral to other professionals as appropriate, and for ensuring provision of maternity services' (Hatem et al, 2008:3).***

Background

A concept analysis on women's satisfaction with giving birth was undertaken by the author in order to guide the literature search and led to the following definition:

> ***'The sense of achievement which the mother feels following childbirth is based on her having personal control over the decisions and the outcome of her labour, and feeling that she has both personal and midwifery support' (McNelis, unpublished concept analysis, 2008).***

The aspirations in the above concept analysis correlate well with some of the important aspects of midwifery-led care expressed by the women in the present study. This includes them wanting to have control over the decisions concerning their labour management and the importance of having both personal and midwifery support.

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A recent Irish study by O'Hare and Fallon (2011) also confirmed that control is important in the experience of childbirth.

The historical background to the development of midwifery in Ireland and the journey towards midwifery-led care has been discussed in detail in studies by the Irish authors Begley and Devane (2003) and Devane et al (2007). In a separate study, Devane and Begley (2004) discussed the issue of safety for the health of both mother and baby in relation to place of birth and concluded that the concept of safety in maternity care is 'ambiguous and ill-defined' (Devane and Begley, 2004:416).

The concepts of risk and safety are often the reasons given for medicalising childbirth and the risk of litigation in Ireland (KPMG, 2008) may explain why midwives' ability to have responsibility for low-risk women is sometimes questioned. However, if midwives were given the freedom to practise within the normal paradigms of childbirth (Gould, 2000) and within the scope of the definition of the midwife (International Confederation of Midwives (ICM), 2005) public awareness of their distinct role would be achieved.

An Irish study by McKenna and Matthews in 2003 highlighted obstetricians apparent lack of acceptance of alternative models of maternity care, in which comparisons were made between the safety of home births and hospital births. However, the authors did suggest that home births are safe, albeit if carefully selected, screened and conducted within a well-regulated system, proving that consultants do recognise the circumstances where home births may be safe (McKenna and Matthews, 2003; 2005). The McKenna and Matthews study does shed light on a gap in the literature about settings for birth in Ireland and underlines the need for more research to be conducted in this area.

In relation to safety, Walsh (2007) was interested in women's apparent lack of concern about risk and safety. The findings from his research demonstrate that the motivational factors contributing to woman's choice in relation to place of birth tend not to be about safety but more about the environment—'calm, homely, absence of busyness'—and from a personal viewpoint, 'welcoming, friendliness, helpfulness' (Walsh, 2007:88). Similar findings were revealed in the present study in that the women commented that the midwives in the MLU made them feel welcome and were very friendly and relaxed.

The concept of risk and safety in relation to midwifery-led care differs from consultant-led care as women cared for in MLUs are in the low-risk category and should therefore be considered a different entity in terms of their risk status. Three comparative evaluations utilising randomised controlled trials of midwifery-led care versus consultant-led care were conducted by Hundley et al (1994), Turnbull et al (1999) and, more recently, Begley et al (2011) in Ireland in the MidU study, in which two MLUs in the Republic of Ireland were evaluated in a randomised controlled trial comparing midwife-led care with medically led care. In all these studies, midwifery-led care was found to be safe, effective and more satisfying for low- risk women.

Women's experiences of midwifery-led care

The first two, and only, purpose-built midwifery-led units opened in the north east of the Republic of Ireland in July 2004 and the first woman gave birth in December of that year. The unit in this study consists of two self-contained birthing rooms, with a birthing pool and all the equipment necessary for a normal birth, hidden away in a specially designed cabinet. The mother stays in the same suite for the duration of her labour and up to 24 hours after the birth if she wishes.

Women's experiences of midwifery-led care and their satisfaction with that experience are used interchangeably in the literature (van Teijlingen et al, 2003), which results in a general lack of discussion on the ambiguity of these two concepts (Waldenström et al, 1996). Women, for example, may be satisfied with the care which they have received but unhappy with some aspect of the birth experience (Bramadat and Driedger, 1993). A satisfactory experience denotes a mediocre level of care whereas a really positive experience might use the word 'excellent' and midwives are encouraged to strive for excellence in the care which they provide (An Bord Altranais, 2005). The literature suggests that women's experience of childbirth is multifaceted and that satisfaction is but one aspect of the overall birth experience, although it too is multidimensional (Johnson et al, 2002; Goodman et al, 2004). Thus in order to explore women's experiences of midwifery-led care it is important to listen to their unique stories to gain an in-depth view of their experiences.

The findings from Saunders et al's (2000) MLU study correlate well with the present study. The women in their study experienced a homely and relaxed atmosphere and had the freedom to move about and make decisions regarding their care during labour, in addition to having their own room and the use of the birthing pool. The concept of homeliness and home-like birthing rooms was explored by Fannin (2004) who cautions

Table 1. Themes and sub-themes

Themes	Homely atmosphere	Woman in control
Sub-themes	Woman being relaxed facilitates labour progress and affects the baby	The woman dictated the pace/relinquished control
	Experienced privacy but was not alone	Ability to cope with the pain of labour
	Personalised care and support	The woman had the knowledge to make decisions and felt respected for her decisions
	Personal support	Expectations were met/ not met

Table 2. Colaizzi's framework for qualitative data analysis (1978)

1. Read all of the subject's descriptions conventionally termed protocols, in order to acquire a feeling for them, a making sense of them
2. Return to each protocol and extract from them phrases or sentences that directly pertain to the investigated phenomenon; this is known as extracting significant statements
3. Try to spell out the meaning of each significant statement, known as formulating meanings
4. Repeat the above for each protocol and organise the aggregate formulated meanings into clusters of themes
5. The results of everything so far are integrated into an exhaustive description of the investigated topic
6. An effort is made to formulate the exhaustive description of the investigated phenomenon in as unequivocal a statement of identification of its fundamental structure as possible
7. A final validating step can be achieved by returning to each subject, and in either a single interview session or a series of interviews, asking the subject about the findings thus far

that converting hospitals into home-like settings may sometimes only mask the continuation of a technological presence and medical control. This view endorses the value of the purpose-built MLU which is separate from the consultant-led unit employed in the present study.

Aim

The aim of this study was to explore women's experiences of a midwifery-led model of care during labour in a midwifery-led unit in the Republic of Ireland.

The objectives were as follows:

- To describe the women's personal experiences of midwifery-led care during labour
- To describe aspects of midwifery-led care that influence women's personal experience of labour
- To inform midwifery practice and make recommendations for midwifery-led care in the future.

Rationale

- There are few studies published in Ireland on women's experience of midwifery-led care
- Midwives need to know about women's experiences of giving birth so that they can provide expert midwifery care tailored to the women's requirements in the future
- Women must be informed so that they can expect not only a choice of models of care but also what standards to expect from midwives and other professionals within maternity services
- The study was necessary as there are only two midwifery-led units in the Republic of Ireland and as they provide an alternative model of maternity care provision they need to be evaluated.

Methods

This descriptive qualitative research used an interpretive phenomenological analysis and Colaizzi's (1978) process of phenomenological data analysis to guide the research study because every woman's experience of childbirth is unique.

A purposive sampling technique was utilised to select the women for the study. The midwives in the MLU recruited women who met the inclusion criteria and invited them to take part in the study, following their consent. The data were collected through a series of individual in-depth, semi-structured interviews with a total of eight participants. Once the interviews were transcribed the transcript was returned to the women for verification, following this some minor adjustments were included.

In the present study it was felt that the uniqueness of the women's experience could only be described through the use of the women's own quotations. The researcher needed to explore the topic in great detail in order to interpret the women's experiences and to tell the story from the participants' point of view so that saturation of data could be achieved with certainty.

Colaizzi's (1978) seven-step framework was adapted for data analysis (*Table 2*).

Ethical approval was granted by Trinity College Dublin, The Health Service Executive and the hospital where the study was conducted.

Findings

The findings revealed two categories namely homely atmosphere and woman in control, which were developed by condensing the theme clusters and emerged as a result of data analysis (*Table 1*).

Homely atmosphere

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One of the most significant findings from this study was that the atmosphere in the MLU was

homely, which was expressed in different ways. For example, two of the women perceived it as part of their feelings.

'We wanted it to be a most homely kind of experience than anything. It was completely different to being in a labour ward.' [Participant 5]

The other woman made the comparison between the MLU and a hospital birth.

'I suppose in hospitals there is that clinical feel about it.' [Participant 1]

For one woman homeliness appeared to be related to the environment.

'It was lovely. Everything was dimmed there was just a couple of lights on, there was a lava lamp on the window and they used torches and mirrors to monitor her birth.' [Participant 7]

The dimmed lighting mentioned above appears to have contributed to the relaxed atmosphere and the use of torches and mirrors possibly generated a sense of relaxation and calm as this woman also stated that:

'I came in relaxed to a relaxed atmosphere and I think that just really helped everything.' [Participant 7]

For another woman, the homeliness experienced was related to the carers.

'It was like being at home they [the midwives] were very homely and the whole atmosphere of the place is very homely.' [Participant 6]

When asked what it was about the midwives that made them 'homely' one woman replied that:

'They didn't have a uniform ... [and] the MLU staff were easy-going.' [Participant 1]

Therefore, a uniform might possibly be considered a barrier to creating a homely environment. Participant 1 also felt relaxed by the lack of equipment.

'You weren't looking at all these monitors and all these different gadgets, which was nice.' [Participant 1]

One woman commented after the interview that she felt very safe and secure in the MLU and described the feeling as being 'cocooned'.

In his study on a birthing unit, Walsh (2007) observed how, through fostering an atmosphere of 'nesting' which was an instinctive role of the midwives, each woman could feel safe and protected in the birthing environment. Nesting is defined by Walsh (2007:112) as 'preparing a safe place for offspring where once born, they can be protected from harm'. The previous comment about feeling cocooned could possibly align itself with the concept of 'nesting'. Stephens (2007) refers to nesting as a relaxing and secure environment where the woman can feel confident and Odent (2001) reminds us that a woman in labour needs to be protected against neocortical stimulation so that her natural oxytocin can flow and help her labour to progress.

The midwife's role in the MLU is one of standing back and assessing rather than interfering with the process of labour. In the study the women may have felt safe not only from medical interference but also from interruptions that might interfere with the progress of labour.

'I wasn't fiddled with or poked and prodded. They just watched and waited and kind of let it happen.' [Participant 7]

This is significant as in Fannin's (2004) study on homeliness she commented on the atmosphere as being an important component in enabling women to feel safe and secure and being conducive to the normal process of labour. She also stated that the homely atmosphere is helped by comfortable surroundings and that the attitude of the carers is an essential component in fostering homeliness.

The findings of the present study echo Fannin's description and the women's quotes demonstrate that in order to generate a homely environment in the MLU the attitude of the midwives who work there is an important factor. Watts et al's (2003) study stated that the homely atmosphere of the MLU and the success in achieving one-to–one care in labour enabled the women to feel more relaxed. Sjöblom et al (2006) offered a description of 'home' as an environment that is safe, secure and designed by the woman herself.

From the present study it could be postulated that both the MLU environment and the attitude of the carers appeared to foster a homely environment. The midwives' attitude was easygoing which enabled the women to feel

relaxed; the midwives accompanied the women on their journey through labour rather than interrupting the natural process.

Woman being relaxed facilitates labour progress and affects the baby

The friendly atmosphere commented upon in the present study appeared to facilitate the spontaneity of the birthing process and was mentioned for all aspects of midwifery-led care, from the antenatal visits, up to and after the birth. The homely atmosphere possibly encouraged the women to feel more relaxed with the result that their labours progressed more smoothly and the whole experience was more easygoing than in conventional settings for birth.

> ***'I was more relaxed and everything just progressed so well.' [Participant 3]***

The baby seemed more content following the birth than after a previous experience in the conventional hospital-birthing unit.

> ***'I don't know whether that is because I was relaxed. She was so content, so peaceful, she was just looking around.' [Participant 8]***

This calmness from the baby echoes the findings of Huber and Sandall (2009) who noted that if the mother was calm the baby was less inclined to cry and appeared more settled overall.

Some women commented that it was the midwives who helped them feel relaxed.

> ***'They made me so relaxed, they helped me all the way.' [Participant 3]***

These findings seem to suggest that familiarity has a positive influence on progress of labour. This is consistent with the findings of Wagner's (2000) study where it was noted that familiar surroundings had a positive affect on labour progression because it helped reduce the woman's anxiety. That familiarity creates a sense of calm resonates with Huber and Sandall's (2009) study, which maintained that calm stems from a feeling of familiarity so that all parties can get to know each other and then know what to expect. If a woman experiences anxiety in labour it causes adrenaline to be released and the contractions to slow down. Adrenaline inhibits the action of the body's natural oxytocin required to stimulate contractions (Robertson, 1994; Buckley, 2005). If this process is interfered with, as might occur if the woman becomes anxious, the labour slows down (Robertson, 1994; Hodnett, 2000). It is evident from the study that the women were encouraged to labour spontaneously thus encouraging good progress and by being relaxed their anxiety was reduced. By employing this relaxed approach to care the midwives were 'being with women' rather than 'doing for women' which correlates with Hunter's definition (2002) that midwife in Old English is defined as 'mid', meaning 'with', and 'wif' as 'wife/women'—encompassing the idea of the midwife journeying with women throughout their pregnancy, labour and birth.

Experienced privacy but was not alone

Each woman was in her own room for both labour and birth, which resulted in generating a sense of privacy.

> ***'It was definitely private ... you had them coming in if you need them they were out of the room, but they were just across from me.' [Participant 1]***

> ***'I felt more private here than I did in the labour ward. It was better.' [Participant 5]***

This finding resonates with those of Odent (1999) and Walsh (2007) who commented on the need for quietness and privacy to contribute to the spontaneity of the labour process.

Personalised care and support

Personal attention from the midwife was considered an important component of the care provided for the mother during labour.

> ***'The girls here were just brilliant, the two girls worked with me.' [Participant 3]***

The women perceived the MLU as their 'own place', possibly because the midwife sought permission to examine them.

> ***'The midwife said "may I see how far on you are, is that okay?"' [Participant 1]***

Great midwifery care was perceived by the women as midwives coming into their room and asking if they were all right and if they needed anything.

> ***'The midwives that were on duty were lovely ... they gave me great care because they kept coming in to see was I okay, was there anything I needed.' [Participant 7]***

That the women experienced a rapport with the midwives was also significant.

> ***'When they came in we would have a bit of a laugh.' [Participant 7]***

Personal support

The women all experienced personal support, which suggests that having their partner present helped contribute to the overall satisfaction with the birth experience.

One woman spoke of the security she felt by having her partner so near to her for this birth.

> ***'It was lovely to have him so close. He held me and I delivered her and I felt very supported by him.' [Participant 7]***

This was a significant finding as this woman explained that in her previous four births her partner was only allowed to hold her hand; the increased closeness was very important to her and was something that she had not experienced in her previous births in the labour ward setting.

Woman in control

For Green and Baston (2003) and O'Hare and Fallon (2011), control and the freedom to exert an influence on the model of care is closely associated with satisfaction with the birth experience.

Control was perceived in different ways; for some women their control was expressed as not feeling under pressure to have the baby.

> ***'If I was in the hospital ward I'd feel as if, there were that many people around me, to be under pressure to have this baby.' [Participant 1]***

The woman dictated the pace/relinquished control

It was significant that the women appreciated being left to their own devices in their labour as this enhanced their birth experience.

> ***'I just wouldn't like to have been fussed, I really just pottered around on my own and that's the way I like to be, I was very happy.' [Participant 7]***

The watch and wait approach spoken of in this study assisted the women in preserving control of the pace of their labour and their environment.

Ability to cope with labour pain

That the women experienced painful contractions but still had a positive experience was significant.

> ***'I did say at one stage "oh I want the epidural." I got the pethidine injection, which relaxed me.' [Participant 3]***

This woman managed to cope with the labour pain without the epidural.

The following excerpt demonstrates her sense of pride and accomplishment:

> ***'I didn't realise that my body was kind of going through the labour thing but it was fabulous.' [Participant 3]***

The fact that the women spoke about the freedom to move about was significant and distinctive to the MLU as it may not always be possible within the confines of the traditional labour ward.

> ***'I had the girls to help me in and out of the water constantly, changing constantly moving around, both because I wanted to and had the area to do it and had the freedom to do it.' [Participant 4]***

Another woman referred to keeping up the flow and momentum of her labour. She knew that she needed to have strong contractions in order for the labour to progress, which is revealing as it demonstrates that she had an understanding that the labour process can be interrupted.

> ***'The nature of the contractions I had, I felt that every time I got comfortable somewhere they slowed and I really wanted to keep the momentum going.' [Participant 7]***

These findings correlate with Gould (2000) and Sutton (2001) who discuss the importance of movement in assisting the progress of labour.

The woman had the knowledge to make decisions and felt respected for her decisions

Without exception, all the women in the study appeared to have the necessary knowledge to enable them to make decisions about their care during labour as they had attended the antenatal classes.

> ***'It was my own decision that I got to do everything that I wanted to do.' [Participant 5]***

'... but when it came to give birth to her I chose to go back on the birthing stool and it was great because I was upright and it was important to me not to be lying down, not to be strapped in, I didn't want to feel hemmed in.' [Participant 7]

When women are encouraged to make decisions about their care during labour it is referred to by Green and Baston (2003) as external control, because being able to make decisions for oneself facilitates empowerment. The present study aligns itself with the literature, which supports the view that when women feel empowered to make decisions in their labour they achieve greater satisfaction, enhancing their birth experience (O'Hare and Fallon, 2011).

Expectations were met/not met

In the context of the overall expectations and anticipation of a healthy baby, other less important factors such as a planned waterbirth can be compromised without affecting the experience in a negative way.

When asked if she was disappointed about not having a waterbirth, one woman replied:

'Not if I had the choice of having the baby in 20 minutes or getting into the water it was great that it was so fast but I wasn't disappointed.' [Participant 6]

Limitations of the present study

Possible limitations include both the small sample size and the use of a single location for the research setting. However, the size of the sample may be justified as it is in accordance with an interpretive approach to research methodology. The use of the single location could potentially mean that the experiences of these women were unique to that particular setting.

Notwithstanding these limitations, there are valuable lessons to be learned from the women's experience of midwifery-led care in the present study and, despite these limitations, important implications for improvements in midwifery practice have been highlighted. One of the lessons that can be learned from doing this research is that midwives need to be cognisant of how their attitude can influence a woman's experience of labour and birth. Midwives need to be aware of their interactions and also how they approach women in their care. It may have been beneficial to observe the women's labour and then speak to them about their experience, which would have added richness to the data.

Women in the study felt more relaxed in the midwife-led unit, leading to a positive birth experience

Midwifery-led care

Based on the study, the essence of midwifery-led care consists of a friendly, relaxed atmosphere created by midwives through showing respect for the women's decisions. This facilitates them to labour in their own way, in their own time, which is in keeping with the philosophy of the MLU. The philosophy of the MLU provides for an environment that respects a woman's wishes and her right to make decisions about her care, and facilitates good communication and control with appropriate support from the midwife. The study indicates that the philosophy works in practice. Therefore, irrespective of where the birth takes place, a midwife is in a key position to foster a de-medicalised, woman-centred environment for normal, healthy labouring women by employing a calm, unhurried attitude to the women in her care and by possessing a philosophy of normality in relation to childbirth.

Implications for future research

The ethos of the MLU is strikingly different from the ethos in a consultant-led unit possibly due to the fact that the MLU caters for low-risk women. The ethos of the MLU, namely the concepts of partnership with women, women-centred care and woman in control, could possibly be transferred in a financially feasible way to other settings to facilitate women in giving birth.

RESEARCH

The main consideration in relation to the philosophy of the MLU that was apparent from the study was the attitude of the midwives. The women noted that the midwives possessed a calm and unhurried attitude to their care. It is proposed therefore, that a study of midwives' attitudes to childbirth in the MLU, versus a consultant-led unit, be conducted in order to explicate midwives' perceptions of the potential differences between the two models of care.

Although homeliness has been acknowledged in the findings, it could be explored in more depth in order to gain a deeper understanding of its meaning for labouring women. This could be achieved by asking women to define what they mean by homely environment. The issue of safety and nesting also needs to be explored to establish the connection between these two important concepts.

The findings of this study highlight the components of midwifery-led care during labour that are important for women who have experienced care at one site. It would be important to study other MLUs in order to compare the findings and to establish if similarities exist with the same philosophy of care elsewhere. Consequently, it may demonstrate 'typicality', meaning that the results are typical across similar settings (Holloway and Wheeler, 2002). In addition, a national study to include all available models of midwifery-led care would also prove beneficial, to examine women's preferences for maternity care and the cost effectiveness of different models.

The findings demonstrated the importance of continuity of care especially in relation to care during labour. It would be necessary to explore women's understanding of both the meaning, and the effectiveness of continuity of carer during labour and to further develop models of care that enhance relational continuity, as this was the aspect of continuity that the women in the study deemed important.

Key points

- The experience of giving birth may have profound immediate and long-term affects on the overall health of a woman, and on the mother–infant relationship
- The essence of midwifery-led care consists of a friendly, relaxed atmosphere created by midwives through showing respect for the women's decisions and thus facilitating them to labour in their own way, in their own time
- Midwives' knowledge about women's experiences of giving birth enables them to provide expert midwifery care tailored to the women's wishes and requirements
- By possessing a philosophy of normality in relation to childbirth, midwives are in a key position to foster a de-medicalised, woman-centred environment for normal, healthy labouring women by employing a calm unhurried attitude to the women in their care

Conclusion

At the beginning of the 20th century, most midwifery practised in Ireland was in the community and as time moves on the wheels will continue to turn so that women will be facilitated to give birth in more homely settings under the auspices of midwifery-led care.

The findings from the present study provide concrete examples on the aspects of midwifery-led care which these women deemed important. These factors include a homely environment, continuity of care during labour and reduced interventions during labour. Other factors unique to the present study include a friendly relaxed atmosphere, respect and support for women shown by midwives, and women feeling in control of decisions about their care during labour. Further research is necessary to establish if there are similarities in other models of midwifery-led care in Ireland.

Implications for practice

- Consider expanding the midwifery-led service to a wider population of low-risk women in Ireland as recommended in the Kinder report (2001)
- The unique features of this model could be applied to all models of care including consultant-led care
- A relaxed and calm attitude from midwives and carers is vital
- Women need to be informed so that they are in control of decisions about their care during labour
- Continuity of care should be provided, especially during labour
- Non-pharmacological methods of pain relief should be encouraged
- Midwifery education needs to focus on labour as a natural event
- Postnatal support at home as required. **BJM**

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Midwives' supervisory styles and leadership role as experienced by Norwegian mothers in the context of a fear of childbirth

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Midwives' supervisory styles and leadership role as experienced by Norwegian mothers in the context of a fear of childbirth

Aim The aim of the present study was to describe the midwives' supervisory style and leadership role as experienced by pregnant women and new mothers in the context of a fear of childbirth.
Background A service led by midwives can influence the quality of care.
Methods The sample consisted of 13 mothers. Data were interpreted by means of qualitative content analysis.
Results The findings revealed that the midwives' supervisory styles were related to their ability to create a trusting and caring relationship, demonstrate problem-solving capacity, and showing willingness, preparedness and courage to support the women. The midwives' leadership role was described as involving a crucial set of professional management skills and techniques.
Conclusion The findings have strengthened the argument for the provision of continuity of care to women who are afraid of childbirth. Further studies should focus more specifically on the implementation of research in practice.
Implication for nursing management It is necessary for midwives to demonstrate leadership in order to develop practice, predict challenges and changes, provide different care delivery models and acquire an evidence base for care. This also demands systematic supervision to improve care outcomes.

Keywords: fear of childbirth, leadership, midwife, models of care, supervision

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Introduction

A service led by midwives based on a continuity of care model can influence the quality of maternal care (Farquhar *et al.* 2000, Homer *et al.* 2008). The midwives' supervisory style and leadership role have an impact on the women's needs and provide support by concentrating on the pregnancy, childbirth and the postpartum period (Homer *et al.* 2002). Midwives' knowledge and competence affect the care they provide and are reflected in the women's experiences of assessment during pregnancy and childbirth (Salomonsson *et al.* in press). Supervision and leadership are necessary for professional development and the acquisition of new skills, which involves reflection on practice and the evolvement of a deeper understanding of the relationship between expectant women and their family members.

Supervision and leadership influence the quality of maternal care (Gamble *et al.* 2004). However, supervision requires organizational support (McSherry *et al.*

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2002). There are different definitions of supervision, several of which describe learning through a process of reflection (Severinsson 1995a, Lyth 2000, Ekebergh 2004) by means of models (Butterworth *et al.* 1996) and interpersonal support. No clear definition of midwife-led service/supervision was found but, according to Richardson and Cunliffe (2003), activities that can be linked to practice are: assessment, referral method, diagnostic tests/consultations, prescription, decision-making and discharge. All of these activities are very important for the outcomes of care and could be improved by the development of a formal education in supervision and leadership, evaluation of the outcomes of planned care and opportunities for supervised practice (Drazek 2005).

Studies of midwives' views of supervision and their leadership role are scare. A Swedish study by Larsson *et al.* (2009) demonstrated that the midwives' professional role and identity in society are changing. The midwives reported that their professional role had become more limited and that their professional identity was challenged by increased medical technology, other professionals and contemporary parents. In addition, a loss of control may increase the risk of illness and burn-out symptoms, which should be considered by supervisors and managers. Deery (2005) explored midwives' support needs as well as the effect of clinical group supervision and concluded that effective midwifery support is required to educationally prepare midwives for difficult situations. Gamble *et al.* (2004) explored midwives' strategies for facilitating recovery after a traumatic childbirth by means of focus groups and identified three themes: opportunities to talk about the birth, developing an understanding of events and minimizing guilt. Nursing leadership has been reported as essential for promoting quality of care (Newhouse 2007). Definitions of leadership are generally consistent with classic organizational and management theorists (Bass & Stogdill 1990, Gifford *et al.* 2007), although over the years leadership theories have developed towards transformative and transactional leadership styles (Gifford *et al.* 2007). Moreover, emotionally intelligent nurse leadership comprised of self-awareness and supervisory skills that lead to positive empowerment processes and high-quality care characterized by resilience, innovation and change has been described as important (Akerjordet & Severinsson 2008).

Becoming a mother is a major transition to adulthood and a change in everyday life (Berg & Dahlberg 1998). This transition influences women in several ways and therefore they need support from their families but also from the health care services. It is necessary to identify vulnerability as well as other risk and protective factors because of the fact that they vary in line with individual and family characteristics. This is particularly important in the case of women who experience a fear of childbirth. There are a number of possible reasons why women may suffer from a fear of childbirth, including mothers' previous experiences of birth. Such experiences can affect their reproductive health and make them unwilling to go through another pregnancy. In some cases it can also lead to post-traumatic stress disorder (Wijma *et al.* 1997, White *et al.* 2006) and postpartum depression (Akerjordet & Severinsson 2009, Severinsson *et al.* 2010). One study by Sinclair and Murray (1998) indicates that postpartum depression can have effects on the cognitive and emotional development of the child.

In summary, the midwives' supervision and leadership role concentrate on pregnancy, childbirth and the postpartum period. Previous research has revealed that different models can be implemented in the provision of care. However, more knowledge is required about midwives' supervisory style and leadership role in relation to specific situations such as a fear of childbirth. The way in which women are met in a stressful situation such as a fear of childbirth can have negative consequences, which in turn can affect the maternal relationship in early childhood. Thus, this neglected area of midwifery practice needs to be explored. Providing support for women during pregnancy, childbirth and the postpartum period is therefore an important concern for midwives. Further research is needed in order to understand the ways in which the midwives' supervisory styles and leadership role can offer such support to childbearing women and postpartum mothers.

Aim

The aim of the present study was to describe the midwives' supervisory styles and leadership role as experienced by pregnant women and new mothers in the context of a fear of childbirth.

Methods

The present study is a part of an ongoing international programme carried out at the Centre for Women's, Family and Child Health by a research group at Vestfold University College, Norway. The research design is explorative (Polit & Beck 2004) and was chosen because it is a qualitative research method using an

interpretive approach and humanistic inquiry to facilitate understanding of individual experiences (Schneider *et al.* 2007). Another reason was the paucity of research related to supervision and leadership in a midwifery context.

Implementation of the group supervision model

An action-oriented group supervision model (Lantz & Severinsson 2001) was designed to support women who had a fear of giving birth. Four experienced midwives participated in the 30-hours group supervision intervention. The supervision sessions were planned by the qualified nurse supervisor as preparation for their role in a team midwifery model. The first meeting started with a presentation and discussion of the principles and values contained in the model and the contract of commitment to participate in the process in order to ensure continuity, provide a feeling of security, illuminate individual needs and offer support throughout the pregnancy, childbirth and perinatal period. The model was applied in the subsequent sessions, during which the supervisor posed questions related to the midwives' experiences of a fear of childbirth and women's individual needs of special maternity care in order to illuminate and deepen the understanding of professional responsibility (Severinsson 1995b). The focus of the supervision was the midwives' professional identity such as their relationship with colleagues and the women, ethical dilemmas related to working with women suffering from a fear of childbirth, documentation of the women's pregnancy and birth process and their expectations as a midwife. Another strategy was to invite the expectant mothers and fathers to a brief training programme prior to the birth in combination with providing an 'open house', i.e. the father was also invited to take part in the programme when it was possible for them. They were also invited to attend the birth. In addition, the midwives arranged for their patients to participate in discussions with other pregnant women as well as thematic-based group meetings. One of the four midwives attended the women during the birth.

Ethical considerations

The Regional Committee for Medical and Health Research Ethics in Norway (No. 2.2007.561) and the Norwegian Social Sciences Data Service (No. 14725) approved the study. All the women received information about the aim of the study and were also informed about confidentiality, their right to withdraw at any time and that if they wished, they could be referred to an experienced midwife and qualified mental health nurse at the local psychiatric clinic. The World Medical Research Association (2004) and Humanities and Social Sciences' (2009) rules and guidelines were adhered to at all times.

Participants and data collection

A midwife at a University Hospital on the west coast of Norway recruited the women who participated in the present study. A letter of invitation was randomly sent to every third individual (a total of 25 women) from a group that attended an intervention in 2007 to support women suffering from a fear of childbirth (Severinsson *et al.* 2010). An important strategy was that all of the pregnant women had an individual consultation with one of the four midwives on at least three occasions before giving birth to achieve continuity in the relationship. The interviews were conducted 1–1.5 years after the intervention. A total of 13 women agreed to participate in the interviews, which were conducted by the first author (A.L.) in her office, in some cases in the woman's home and in a café. The interviews lasted between 40 and 90 minutes, were audio-taped and transcribed verbatim. The women were aged between 25 and 37 years. Seven of them had had negative experiences of their first childbirth and five reported complications during the first childbirth (three had undergone an emergency caesarean section and two had complications requiring vacuum extraction). The interview questions were open and related to the need to receive supervisory support from the midwives and how the midwives demonstrated leadership.

Interpretative content analysis

The qualitative interpretative content analysis (Graneheim & Lundman 2004) was performed on the basis of the following two questions: How did the women experience the supervision provided by the midwives? and How did the midwives use their leadership role to support the women during pregnancy, birth and the postnatal period? The authors then grouped the statements derived from the responses to the questions and conducted a structural analysis. This process of analysis and interpretation made it possible to achieve a dialectic movement between the parts and the whole of the text. Finally, the authors searched for a pattern to identify the midwives' supervisory styles and leadership in the context of a fear of childbirth.

Results

In general, the midwives' competence and how they supervised the women's pregnancy, birth and the postnatal period were described by their capacity to encompass the therapeutic, interpersonal and professional styles. The midwives' supervisory styles were identified on the basis of their emotional, cognitive and personal skills, whereas their leadership role was found to consist of professional management skills and techniques.

Midwives' supervisory style

A number of themes emerged from the data and were characterized as:

- creating a trusting and caring relationship;
- demonstrating problem-solving capacity; and
- showing willingness, preparedness and courage to provide support, which reflected the midwives' long and multi-facetted clinical experience as health care professionals (Table 1).

The themes contained several sub-themes (referred to by the numbers of the themes above):

- being sensitive to individual needs and wishes, acting in accordance with and responding to individual desires and needs, and ability to provide hope and confirmation;
- being understanding and explaining the reasons for a fear of childbirth; and
- showing involvement and demonstrating courage to handle acute situations beyond normal routines.

Creating a trusting and caring relationship
The creation of a trusting relationship with the women suffering from a fear of childbirth was based on knowledge of the individual woman's situation and familiarity with her special needs and wishes. It also included the ability to act and be focused on the tasks, as well as ensuring a pleasant and safe environment, all of which are aspects that helped the women to feel secure.

Sub-theme: being sensitive to individual needs and wishes. The following statement is evidence of the close relationship between the midwife and the woman. It also indicates increased satisfaction and a sense of safety and control in their relationship.

'I felt so safe during the birth, these midwives are unique people. My midwife was so professional and clever. It was a fantastic birth. I had a very close relationship with her (midwife), she knew exactly what I needed'.

Sub-theme: acting in accordance with and responding to individual needs. Closely linked to sensitivity to individual needs and desires was the fact that the midwives supervised by acting in accordance with and responding to these needs and desires. This type of supervision was especially beneficial.

'You do not talk to everyone about your anxiety. I had a person (midwife) I could phone and one of them was always on duty. That certainty was good enough for me. They focused on and confirmed my emotional dimension and it gave me the security I needed'.

Sub-theme: ability to provide hope and confirmation. This sub-theme illustrates the close relationship with a woman who was feeling uncomfortable and vulnerable and her experience of the midwife who cared for her.

'I could talk about my thoughts and worries, and I believed that I was well in control over my feelings but then I started to cry. She supported me and explained that it should not be like my previous birth, and I believed her, she gave me faith'.

Demonstrating a problem-solving capacity
The second theme illustrates the midwives' problem-solving capacity which was based on understanding and openness to different decisions and solutions related to a fear of childbirth.

Sub-theme: being understanding. A further finding from the study was that the experience of being understood was beneficial in cases where the woman had had negative experiences of a previous birth.

Table 1
Midwives' supervisory styles

Theme	Creating a trusting and caring relationship	Demonstrating problems-solving capacity	Showing willingness, preparedness and courage to support
Sub theme	Being sensitive to individual needs and wishes acting in accordance with and responding to individual needs, and ability to provide hope and confirmation	Being understanding and explaining the reasons for a fear of childbirth	Showing involvement and demonstrating courage to handle acute situations beyond normal routines

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'The midwives were open to the idea of a caesarean if I wanted one. They never forced us to go through a vaginal birth if we did not want to. The midwife said: caesarean can be one birth alternative. I was very afraid and that helped me to sleep at nights'.

Another statement was: 'I felt so special and well cared for. I was not considered an expert despite the fact that I had given birth to three children before'.

Sub-theme: explaining the reasons for a fear of childbirth. Examples of cognitive experiences and learning about the reasons for a fear of childbirth were also reported.

'In my situation the feeling of security influenced the birth. She (the midwife) knew what I was afraid of. I had an appointment and could talk about it before the birth. The team of midwives had time to focus on the birth and my feelings about it. They knew what they were talking about, and I knew that they would be there when it was time for the birth and could influence the birth process'.

This statement reflects the benefits of the team midwifery model and the possibility of being attended to by a familiar midwife during labour. The statement above indicates that the woman felt confident that the midwives had knowledge of her situation, in addition to competence to supervise and collaborate in the care, i.e. communication and relationships.

Showing willingness, preparedness and courage to support the women

A prominent theme in the data was the women's need for support as a consequence of their fear of childbirth. They reported the midwives' willingness to support and encourage them to manage their situation. The following quotations illustrate involvement and courage to handle acute situations beyond normal routines.

'She (the midwife) really wanted me to make it. I could take all the time I needed. She was my supervisor during the pregnancy and birth''.

''It was caring from day one. She (the midwife) had a special view of commitment that few people have today. I felt confirmed as the person I am and why I was afraid of giving birth'.

'For me it was very important that she could say ''No'' to the physician when I had told her that I did not want students in the room. It is not easy when you are lying there and feeling exhausted, I am a person who says yes far too often. She was my voice during the labour and birth. She took responsibility for supervising me all the way'.

Midwives' leadership role

The theme identified was employing a crucial set of professional management skills and techniques, which comprised the following sub-themes (Table 2):

- assuming responsibility for managing the process;
- assuming responsibility for creating a conducive work climate; and
- empowering the women.

The theme reflected the women's experiences of their need to be coached during pregnancy, birth and the postnatal period. The midwives' managerial style and how they developed it influenced the caring process. Their professional management skills and competence included emotional commitment, whereas their involvement in the individual woman's situation increased her experience of being empowered.

Table 2
Midwives' leadership role

Theme	Employing a crucial set of professional management skills and techniques
Sub theme	Assuming responsibility for managing the process
	Assuming responsibility for creating a conducive work climate
	Empowering the women

Employing a crucial set of professional management skills and techniques

The midwives' leadership was described as competent, as they assumed responsibility for motivating, inspiring and managing the process beyond what was normal in the organization in order to achieve changes that helped each individual woman.

Sub-theme: assuming responsibility for managing the process. The following quotation illustrates the importance of a planned model linked to the women's experiences of flexible care during labour and birth but also a strategy for change that may occur during the steps in the process.

'My midwife was so very professional and competent. Although I had a difficult birth and a lot of pain she looked after and respected me and I trusted her fully. She said the right things and also managed to say no to other people who wanted to follow the birth with whom I felt uncomfortable'.

The woman reported that the midwife invited her to participate in planning for the birth, monitored quality and safety as well as offered her relevant information about different modes of delivery.

'I felt so safe. I knew the midwife team would help me and that I could choose the mode of delivery. I knew that if I requested a caesarean I could have one, but I wanted to give birth in a natural way. The team gave me a sense of security, we worked together, they took great responsibility and were prepared for a traumatic birth''.

Another woman expressed: 'I trusted the midwife, she was the professional person. She made me feel safe and talked to me and said just the right things. She showed me respect and set boundaries and I trusted her quality management. She monitored the birth and controlled everything in a warm and professional way'.

Sub-theme: assuming responsibility for creating a conducive work climate. The midwives' responsiveness included assuming responsibility for creating a conducive work climate. As one woman stated, 'I stopped worrying about the birth because the midwife was so knowledgeable, she listened, was prepared and present all the time. I really trusted her to take responsibility and lead me through the birth. She and the other midwives in the team also took responsibility for the postnatal period by keeping in contact by phone'.

Sub-theme: empowering the women. The women in the present study considered it important to be able to successfully handle and control their situation during pregnancy and the forthcoming birth. The way the midwife managed the situation also affected the women's experiences of being empowered.

Statement: 'I have a much better self-esteem today, as I became stronger due to my relationship with the midwife. I felt that I could ''walk on my two feet'' and that I could better cope with other things in my life. Before that I felt that I was not good enough to do the same things as other people'.

Discussion

The aim of the present study was to describe the midwives' supervisory styles and leadership role as experienced by pregnant women and new mothers in the context of a fear of childbirth. The data were collected by means of interviews with participants in an action research programme aimed at supporting women who had a fear of giving birth. A limitation of this method is that the participants formed a homogeneous group. The women interviewed were all at increased risk and had attended the intervention. On the other hand, they had insight into the phenomenon, which may contribute to a deeper understanding of a fear of childbirth. Another limitation is that this empirical study was performed in a Norwegian context. Fear of childbirth is an international problem. Although the authors referred to various sources of knowledge when interpreting the result and one of the researchers has many years of international experience, the study is still limited to the Norwegian context.

The authors attempted to achieve trustworthiness by analysing the data in different steps and using representative quotations from the transcribed text. They had a special pre-understanding of maternal care from a mental health perspective, as in different ways (as registered psychiatric nurses and a researcher in the field) they have worked with people who suffer from fear and anxiety.

The authors independently read the text from each of the women, after which they met and compared their analyses in order to decide on the themes. They subsequently met on a second occasion to discuss the text as a whole in order to reach consensus about the content as well as the labelling of the themes while taking account of the aim of the study. The analysis had good agreement, which can be seen as a validation of the findings.

The findings of the present study expand previous research in that to create a trusting and caring relationship between the pregnant woman and the midwife is of the utmost importance. There is no doubt that the continuity of care model influenced this finding by taking account of the women's individual situation and, in particular, addressing their need for support in relation to a fear of childbirth. There are similarities between our findings and research from Australia (Homer *et al.* 2002). Homer *et al.* (2002) found that almost 80% of women attending an intervention aimed at providing continuity of care during labour from one of the team midwives had a significantly higher 'sense of control during labour and birth'. It was also reported that the women 'knew' the midwife who cared for them (63%) compared with 21% in the control group. The women in this study trusted the 'known' midwife's way of supervising them through the birth. Having a trusting relationship with the midwife encouraged the women to go through a vaginal birth. The opportunity to participate in planning the birth strengthened the women's ability to go through with it. Several of the participants started out with the desire for a caesarean as the mode of delivery but most of them subsequently changed their minds. Midwives' willingness and preparedness to support the woman have been reported previously (Berg *et al.* 1996).

The present study revealed that the way in which the midwife supervised helped the woman to develop courage. In supervision, courage can concern daring to share negative experiences of the care provided. When the midwife who acts as supervisor is courageous, she can serve as a model that helps the woman to develop courage. Moreover, the supervision process influences self-awareness and the willingness to assume responsibility (Berggren & Severinsson 2006). In some Scandinavian countries supervision is commonly used to facilitate the sharing of experiences among staff (Hyrkäs *et al.* 2002, 2005, Bégat *et al.* 2005). In the present study it was considered to be a good tool for supporting women who had a fear of childbirth. The essence of supervision is the empowering and nurturing relationship between the supervisor, i.e. the midwife and the woman. As the relationship is the most important factor for the pregnant woman, it is not surprising that it influenced the women in the present study in a positive way. The midwives confirmed, showed empathy and were present in their encounter with the women and these factors influenced the latter by strengthening their sense of security. In addition, the quality of the relationship may enhance the women's situation and influence their control over it, thereby increasing satisfaction with the care provided. Nevertheless, the relationship also depends on the quality of supervision, thus the midwives in the present study also attended a supervision group (Severinsson *et al.* 2010). It has been reported that supervision influences staff members' sensitivity to patient needs and professional growth, but that it has no effect on their working conditions such as the work environment or routines (Severinsson & Hallberg 1996).

Supervision is beneficial, irrespective of the midwives' seniority, knowledge and skills. There are several supervision models and no single model will meet the needs of all midwives. Nevertheless, a group supervision model with 4–6 supervisees is advantageous, as it provides the possibility to share experiences, knowledge and skills. It can also be assumed that one effect of supervision was an increased understanding of ethical issues. The present study highlighted the midwives' ability to solve problems and assume responsibility for coaching as part of their leadership role. Their management skills and techniques also included assuming responsibility for creating a conducive work climate. Thus, supervision can facilitate autonomy, reduce the culture of shame (not being a good enough mother when giving birth) as well as stress in relation to the birth. When they know each other, both the midwife and the woman in labour can concentrate on the birth itself. It has also been indicated that supervision can help midwives to manage difficult clinical situations.

This study revealed that the midwives empowered the women by helping them to deal with their fear of childbirth by explaining the reasons for it, thereby leading to a sense of mastery. From the women's perspective it was important to feel secure. According to Willemyns *et al.* (2003), it seems reasonable to assume that the sense of security occurred as a consequence of the midwives' communication within the continuity of care model. The sense of security is also dependent on the competence and leadership skills of each individual midwife. This strategy can be discussed further in terms of the way in which trust is taken into account of by health systems, on what is it based and what endangers it in the organizational system (Gilson 2006). One way of rethinking leadership in midwifery can involve emotional intelligence, which is a necessary component as it relates to job satisfaction and quality of care (Akerjordet & Severinsson 2008). Women's mental health is vulnerable during the post- and perinatal period (Riecher-Rössler & Steiner 2005), therefore a model such as continuity of care and supervision should be applied in order to decrease the biological and psychosocial stressors.

Conclusion and implications for nursing management

In conclusion, a new finding from this study is a deeper understanding of a fear of childbirth as experienced by pregnant women and new mothers. The midwives' supervisory styles and leadership role were grounded in their commitment to support and supervise the women, thus helping them to develop courage. Moreover, this study underlines the need for support for midwives, who require more overt recognition of their role (Fisher & Webb 2008) in order to provide high-quality and safe care within the complexities of contemporary maternity services (Paeglis 2009). In addition, they require different supervision models for developing competence and leadership, the determining factors for driving health improvement initiatives forward. A research-based education at an advanced level (master and doctoral) is necessary in order to enhance the midwives' capacity to develop the profession. Although such education exists in several countries, it is not yet available in Norway.

The study further underlines the importance of investigating several factors related to a fear of childbirth that have an impact on maternity care, management and service delivery within the context of organizational constraints.

Contributions

Study design: E.S., A.L.; data collection: A.L.; data analysis: A.L., E.S.; manuscript preparation: E.S., A.L.

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Review

What is a *good midwife*? Insights from the literature

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ABSTRACT

Objective: to review the literature around what is considered to be a *good midwife* and in particular what women value in a midwife, in order to identify the gaps in the evidence for future research.
Design: this paper reviews the research in the area of interest over the past 30 years. The literature search focused on the concept of *good midwife* using synonyms and antonyms. The inclusion criteria included language (English or Italian). The examined databases were Medline, Maternity and Infant Care, Applied Social Sciences Index and Abstract and CINAHL.
Setting: studies conducted in high-income countries were taken into account. A focused review of papers which explicitly investigated *what a good midwife means* and a thematic analysis on what women value in a midwife were carried out.
Participants: different standpoints have been considered (midwives, student midwives, women and their partners), focusing in particular on women viewpoint.
Findings: the literature review reveals information about what is considered to be a *good midwife* from a range of perspectives and what women value in a midwife. A *good midwife* should possess several attributes: theoretical knowledge, professional competencies, personal qualities, communication skills and moral/ethical values. According to the thematic analysis around what childbearing women value in a midwife, frequent key-themes emerging from the literature were: support, possibility of choice, feeling in control and having appropriate information.
Key conclusions: the meaning of *good midwife* might change according to different actors involved in midwifery care and there is no agreement on the definition of what constitutes a *good midwife*. Furthermore, it is not clear if what women value in a *good midwife* corresponds to the midwives' perception of themselves as good professionals. There is a dearth of information around women's expectations and experiences specifically of a *good midwife*, and even less around whether this changes according to where they give birth.
Implications for practice: this literature review seeks to stimulate debate and reflection among midwives and professionals involved in the childbearing event, in order to fulfil women's expectations of their midwife and increase their satisfaction with the birth experience. The identification of the gaps in the evidence provided the starting point and allowed the development of research questions and methodology for an ongoing doctoral research. On the basis of the gaps in the evidence, the doctoral research will explore and seek to explain nulliparous women's expectations and experiences of a *good midwife* in the context of different planned place of birth, using a Grounded Theory methodology. It is also expected that the findings of this literature review will stimulate additional research in this area to ultimately inform midwifery practice and midwifery educational programmes.

Contents

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Introduction

This paper reports the literature review around what is considered to be a *good midwife* and in particular what women value in a midwife, in order to identify the gaps in the evidence for future research. The author's personal interest in what is considered to be a *good midwife* comes mainly from experience in midwifery practice, the debates and discussions with colleagues around the topic and reflection on midwives' behaviours in their everyday practice. In fact, maternity services are sometimes characterised by a lack of caring for women and their families. Short-staffing, busyness and medicalised models of care may contribute to this perception (Larkin et al., 2012). Reflecting on professional values, attitudes, competencies and quality of midwifery care, a fundamental question arises: what is a *good midwife*. The answer is probably ambiguous, since it could have different meanings and interpretations, related to who answers the question or when and where it is answered.

The word *midwife* is literally translated *with woman*. A regulatory definition of the midwife is endorsed by the International Confederation of Midwives (ICM), the World Health Organization (WHO) and the International Federation of Gynecology and Obstetrics (FIGO): 'the midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant'. In particular, the International Confederation of Midwives (Fullerton et al., 2011) delineates the knowledge, skills and behaviour that would characterise the domain of competencies of the midwife who is educated according to the international definition of the profession.

In trying to answer the question of what constitutes a *good midwife*, it has to be acknowledged that the word *good* could have different meanings and understandings. In fact, it can be defined in several ways, depending on the context and the subject or object it is referred to. The Oxford Dictionary (online) defines *good* as follows: to be desired or approved of; having the required qualities; of a high standard; possessing or displaying moral virtue; giving pleasure; enjoyable or satisfying; thorough; valid. However, the definition of a *good midwife* as one with satisfactory enough theoretical knowledge and practical skills guarantees a minimum standard but does not encourage excellence: in the sense that the professional is required to perform to a proficient minimum. From this perspective, personal attitudes seem to be irrelevant and what is really important is the absence of incompetence instead of the possession of excellence, forgetting other essential characteristics of midwifery such as personal qualities and moral/ethical values (Sellman, 2007).

The International Confederation of Midwives (*ICM*) supports, represents and works to strengthen professional associations of midwives throughout the world. The ICM works with midwives and midwifery associations globally to secure women's right and access to midwifery care before, during and after childbirth. *Essential Competencies for Basic Midwifery Practice* were published in 2010. The key midwifery concepts that define the unique role of midwives in promoting the health of women and childbearing families have been identified as follows: partnership with women; respect for human dignity and rights; advocacy for women; cultural sensitivity; focus on health promotion and disease prevention that views pregnancy as a normal life event.

As the doctoral study which will follow this literature review will take place in UK, what the Nursing and Midwifery Council (NMC) says about good midwifery practice has been taken into account. The NMC is a regulatory body that regulates midwives and nurses in England, Wales, Scotland, Northern Ireland and the Islands. The Nursing and Midwifery Council sets standards of behaviours, performances and ethics for midwives. Following this code of conduct (last version 2008), the midwives that meet these standards are expected to give high quality care throughout their professional life. In fact, the code is central to good midwifery, and all midwives must follow it in order to be able to work legally and safely. The four central principles of the code are: individualised care and respect for dignity; multidisciplinary work and promotion of health; high standards of practice and care; being open and honest with integrity and upholding the reputation of the profession. Any midwife must meet these standards and regularly demonstrate that they are meeting them, in order to remain on the register and be eligible to work in the UK.

Neither the ICM nor the NMC speak specifically about the notion of *good midwife*. In fact, they refer only to the term *midwife*, identifying skills and competencies required of them at the point of registration and throughout their professional career. In addition to this, the standards of ICM and code of ethics of NMC have been entirely developed by professionals. However, the needs of women might not match with the midwives' perceptions of themselves as good caregivers. This issue will be addressed later in this paper.

Methods

This paper reviews the research in the area of interest over the past 30 years. The literature search focused on the concept of *good midwife* using synonyms and antonyms as key words. Different standpoints have been considered (midwives, student midwives, women and their partners). The inclusion criteria included language (English or Italian – the author is Italian). Studies conducted in high-income countries were taken into account. The examined databases were Medline, Maternity and Infant Care, Applied Social Sciences Index and Abstract and CINAHL.

A focused review of papers which explicitly investigated *what a good midwife means* will be presented. In order to focus on the specific definition of what a *good midwife* is, a selection of papers was reviewed. The inclusion criterion was the use of the terms *good midwife* or *good midwifery* in the title and/or in the aim of papers. Only six papers explicitly investigated *what a good midwife means*, including an integrative review (Nicholls and Webb, 2006), a Delphi study (Nicholls et al., 2011), an evolving theory (Halldorsdottir and

Karlsdottir, 2011) and three qualitative researches (Byrom and Downe, 2010; Carolan, 2010, 2013).

A rationale will be given for focusing on women's standpoint and a thematic analysis on what childbearing women value in a midwife during labour and birth will be included. The papers were selected from the body of literature identified in the literature search around the concept of *good midwife*. The inclusion of the studies in the thematic analysis was done on the basis of the methodological approach (inclusion criteria: empirical research), the sample (inclusion criteria: women as participants) and pragmatic reasons (inclusion criteria: focus of the study totally or partially related to the women's views of the midwife during labour and birth). Only studies conducted in high-income countries were examined. Time limits and sample size were not considered as criteria for the selection of the studies. Six papers have been included in the thematic analysis. The studies were conducted over a 23 years period (from 1987 to 2010) and the sample sizes vary from eight to 825 women. Women's partners are involved in two of the selected studies. Methodologies were variously described as qualitative ($n=4$) (Walker et al., 1995; Berg et al., 1996; Brown et al., 2009; Dahlen et al., 2010), using a phenomenological ($n=1$) (Berg et al., 1996) or Grounded Theory approach ($n=3$) (Walker et al., 1995; Brown et al., 2009; Dahlen et al., 2010). Two authors utilised quantitative methods (Green et al., 1990; Tumblin and Simkin, 2001). The selected papers for the thematic analysis about what women value in a midwife have been critically appraised by the author through validated tools, in order to increase the methodological strength of this work. The appraisal of the qualitative studies was done using the tool developed by Walsh and Downe (2006). The quantitative elements of the papers were appraised using the *Critical Appraisal Skills Programme* tools (Public Health Resource Unit, 2006). Details of the papers and associated critique are reported in Table 1. The selected papers were read several times in order to grasp the essential features and to identify the main themes. Themes recurring in at least three of the total six papers have been considered by the researcher. The contents of the papers have been utilised to describe and explain the themes. It must be acknowledged that the authors of the selected studies had not explicitly asked to women what they consider to be a *good midwife*. However, they either totally or partially relate to what women value in a midwife. Some references to the papers of the broader body of the literature will be included in the thematic analysis in order to contextualise the recurring themes. Finally, literature gaps in knowledge of the meaning of *good midwife* will be given.

Findings

What is a good midwife?

The term *good* in relation to midwives' attributes and quality of midwifery practice has been widely debated and researched. According to the literature about this topic, different meanings and interpretations are mainly related to the concept of what is a *good midwife*.

Nicholls and Webb (2006) aimed at identifying a research-based definition of a *good midwife* that could be used as an operational definition for the purposes of curriculum development. They carried out an integrative review of methodologically-diverse research papers. Thirty-three research-based papers were included in the review. The authors found that the principal attribute in these papers on being a *good midwife* was having good communication skills. Being compassionate, kind, supportive (affective domain), knowledgeable (cognitive domain) and skilful (psychomotor domain) also made major contributions. Being involved in education and research were necessary requirements, and midwives' abilities to treat women as individuals, adopting a caring approach and being there for women were essential. Furthermore, the authors argue that a *good midwife* can compensate for poor management systems. However, the researchers do not distinguish between the different standpoints of midwives, students, women and their partners. Thus, it is not clear if what women value in a *good midwife* corresponds to the midwives' perception of themselves as good professionals.

After noting the lack of studies addressing the overarching question 'What makes a *good midwife*?', Nicholls et al. (2011) investigated the perceptions of the *good midwife* using a Delphi questionnaire. The sample included postnatal women, midwives and midwifery educators ($n=226$). The statements with the highest mean scores were related to lifelong learning, woman-centred care and again good communication skills. The authors found that being a lifelong learner and the development of good interpersonal skills are as important as technical competence in making a *good midwife*. Again, the researchers do not distinguish between women and midwives' answers in the sections of findings and discussion of data in this study. Thus, it is difficult to disentangle the participants' accounts.

Halldorsdottir and Karlsdottir (2011) introduced an evolving theory on the empowerment of childbearing women, where the midwife's professionalism is central. The theory is synthesised from nine datasets from nine original research papers of their own studies and scholarly work, and more than 300 studies were reviewed for clarification and confirmation. According to the theory, the professional midwife cares for the childbearing woman and her family and is professionally competent. She/he has professional wisdom and interpersonal competence and is capable of empowering communication and positive partnership with the woman and her family. Furthermore, the professional midwife develops herself both personally and professionally. The author states that this evolving theory must be regularly reviewed both in the light of current midwifery knowledge and conceptions around the idea of who is considered to be a *good midwife*. However, their theory is limited because it is descriptive rather than explanatory. Furthermore, the identified themes are not comprehensively discussed in the findings.

Considering the standpoint of midwives ($n=10$), Byrom and Downe (2010) investigated the characteristics of the *good midwife* through a phenomenological approach. The data analysis underlined two clear dimensions: skilled competence (knowledge, skills and competencies) and emotional intelligence (personal qualities). The authors used an appreciative inquiry method which deliberately focuses on positive characteristics of the midwife. Thus, it has limited utility in distinguishing good qualities and attributes from poor ones.

Student midwives' views ($n=32$) of the *good midwife* have been explored by Carolan (2010, 2013). Carolan (2010) found that first year students spoke of a series of key attributes they felt were important to the role of the midwife: personal qualities and attitudes, belief in women and natural birth, ethical concerns and possession of additional attributes (life experience, cultural knowledge and passion/enthusiasm). Students, early on in their course, showed a clear understanding of the affective attributes required of a *good midwife* but less understanding of requirements of knowledge and competence. Two years later, Carolan (2013) explored third year midwifery students' view of a *good midwife* and it was evident that their perceptions were becoming aligned with the views of qualified midwives. In fact, final year's students acknowledged the importance of safe practice at the same time as supporting women to make decisions. The author brings to light the importance of 'early transition and socialisation into the profession' (Carolan, 2013: 1).

Table 1
Details and critique of the papers included in the thematic analysis

Paper	Research aim	Sample and setting	Methodology	Critique
Berg, M, Lundgren, I, Hermansson, E, Wahlberg, V, 1996 Women's experience of the encounter with the midwife during childbirth Midwifery 12, 11–15	Describing women's experience of the encounter with the midwife during childbirth	18 women (6 primips, 12 multips) two to four days after delivery in the Alternative Birth Care Centre SWEDEN	Qualitative research, Phenomenology, interviews	• Clear purpose and background • Appropriate methodology and methods • Clear interpretation of findings and conclusions • Demonstration of sensitivity to ethical concerns • Limitations of the study and implications for practice outlined • Clear audit trail given • Not discussed: philosophical underpinnings, relationship between researcher and participants, researcher's influence on stages of research process, evidence of how problems/ complications were dealt with, further investigations • The study provides new original insights
Brown, J, Beckhoff, J, Stewart, M, Freeman, T, Kasperski, M, 2009 Women and their partners' perceptions of the key roles of the labour and delivery nurse Clinical Nursing Research 18, 323–335	Examining the perspectives of women and their partners regarding key roles of the labour and delivery nurse during labour and birth	10 heterosexual couples (women and partners interviewed separately) ENGLAND	Qualitative research, Grounded Theory, interviews	• Clear purpose and background • Appropriate methodology and methods • Clear interpretation of findings and conclusions • Demonstration of sensitivity to ethical concerns • Limitations of the study and implications for practice outlined • Clear audit trail given • Not discussed: philosophical underpinnings, relationship between researcher and participants, researcher's influence on stages of research process, evidence of how problems/ complications were dealt with, further investigations • The study provides new original insights
Dahlen, HG, Barclay, LM, Homer, CSE, 2010 The novice birthing: theorising first-time mothers' experiences of birth at home and in hospital in Australia Midwifery 26, 53–63	Exploring first-time mothers' experiences of birth at home and in hospital in Australia	19 first-time mothers who gave birth in different birth settings (home, public hospital, private hospital, birth centre) AUSTRALIA	Qualitative research, Grounded Theory, interviews	• Clear purpose and background • Appropriate methodology and methods • Clear interpretation of findings and conclusions • Demonstration of sensitivity to ethical concerns • Implications for practice outlined • Clear audit trail given • Not discussed: philosophical underpinnings, relationship between researcher and participants, researcher's influence on stages of research process, evidence of how problems/ complications were dealt with, limitations of the study, further investigations • The study provides new original insights
Green, JM, Coupland, VA, Kitzinger, JV, 1990 Expectations, experiences, and psychological outcomes of childbirth: a prospective study of 825 women Birth 17, 15–24	Determining women's expectations, experiences and psychological outcomes of childbirth	825 women booked for delivery in six hospitals in Southeastern England ENGLAND	Quantitative research, questionnaires	• Clear purpose and background • Appropriate methodology and methods • Minimised biases • Complete follow up • Appropriate statistical analysis • Clear interpretation of significant findings and conclusions • Demonstration of sensitivity to ethical concerns • Limitations of the study and

Table 1 (*continued*)

Paper	Research aim	Sample and setting	Methodology	Critique
				implications for practice outlined • Not discussed: further investigations • The study provides new original insights
Tumblin, A, Simkin, P, 2001 Pregnant women's perceptions of their nurse's role during labour and delivery Birth 28, 52–56	Determining nulliparous pregnant women's expectations of their nurse's role during labour and delivery as expressed during the last trimester of pregnancy	57 nulliparous women in childbirth classes NORTH CAROLINA	Quantitative research, surveys	• Clear purpose and background • Appropriate methodology and methods • Minimised biases • Complete follow up • Appropriate statistical analysis • Clear interpretation of significant findings and conclusions • Demonstration of sensitivity to ethical concerns • Limitations of the study, implications for practice and further investigations outlined • The study provides new original insights
Walker, JM, Hall, SM, Thomas, MC, 1995 The experience of labour: a perspective from those receiving care in a midwife-led unit Midwifery 11, 120–129	Elucidate the experience of labour for those receiving any aspect of care in a midwife-led unit	32 women who gave birth in a midwife-led unit and six partners during postnatal period ENGLAND	Qualitative research, Grounded Theory, interviews	• Clear purpose and background • Appropriate methodology and methods • Clear interpretation of findings and conclusions • Demonstration of sensitivity to ethical concerns • Limitations of the study and implications for practice outlined • Clear audit trail given • Not discussed: philosophical underpinnings, relationship between researcher and participants, researcher's influence on stages of research process, evidence of how problems/complications were dealt with, further investigations • The study provides new original insights

According to the findings of the studies cited above (and therefore from a range of perspectives) a *good midwife* should possess several attributes: theoretical knowledge, professional competencies, personal qualities, communication skills and moral/ethical values. However, the meaning of *good midwife* might change according to the ideas of the different actors involved in midwifery care and there is no agreement on the definition of what constitutes a *good midwife*. Furthermore, the different standpoints often overlap and it is difficult to make a clear distinction between them, as in the papers of Nicholls and Webb (2006) and Nicholls et al. (2011). As stated above, it is not clear if what women value in a *good midwife* corresponds to the midwives' perception of themselves as good professionals.

Why focus on the perspective of childbearing women?

The role of the midwife has undergone a number of changes in recent decades, primarily related to a greater emphasis on woman-centered care, both in policy documents (Nursing and Midwifery Council, 2008; International Confederation of Midwives, 2010) and in the research literature (Leap, 2000; Freeman et al., 2004; Fontein, 2009). Woman-centered care is based on the recognition, acknowledgement and respect of the childbearing woman with her distinctive needs, ideas, thoughts, emotions, expectations and wishes about pregnancy, birth and motherhood. In other words, the woman and her baby come first (Fontein, 2009). Green et al. (1988) argued that the woman expects to meet a midwife who will care for her as an individual, supporting her instinctive abilities in becoming a mother. The midwife's main aim should be to attend to the expectant mother and her needs, encouraging her through the birth process and understanding her strengths and weaknesses. Eliasson et al. (2008) argue that because giving birth is such a significant event in a woman's life, it could affect future behaviours of the whole family. Furthermore, positive experiences are embedded in the memory if the midwife has been acting in a caring way (Halldorsdottir and Karlsdottir, 1996). As Waldenstrom (1998) affirms the constant presence of a midwife and good care during birth can increase the woman's satisfaction with her birth experience. Thus, every midwife should consider the importance of the well-being and satisfaction of the woman and her family during the childbearing event.

The importance of the woman's perspective is underlined by Pembroke and Pembroke (2008), arguing that the woman is the principal actor that invites others to be with her as she gives birth. The authors introduce the concept of *genuine hospitality*, debating the appropriateness of referring to the midwife as a host. In fact, the midwife could be seen primarily as the invited guest to the experience of the woman. There is still a place for the appellation *host* in relation to the midwife's role: 'the midwife is

called upon to mentally establish an open space that will be filled by the woman's needs and preferences' (Pembroke and Pembroke, 2008: 325). Furthermore, it has to be acknowledged that the potential for psychological benefit or damage is present at every birth. Caregivers have a great deal of influence on how each woman will remember her experience. In addition to a safe outcome, the goal of a positive memories should guide the midwife's care (Simkin, 1991).

Maternity services and midwifery programmes sometimes seem more focused in what the institutions and regulatory bodies want from midwives. However, it is obvious that women's expectations and experiences of midwifery care are of fundamental importance as a research focus.

In order to address the issues around what constitute a *good midwife*, a thematic analysis about women's perceptions, expectations and understandings of the midwife during labour and birth has been conducted.

What does the childbearing woman value in a midwife? A thematic analysis

On the basis of the rationale previously explained, a thematic analysis was done according to the existing body of knowledge around what childbearing women value in a midwife during labour and birth.

It is clear that women give great importance to the relationship with their midwife as cornerstone of their childbearing event. In particular, the key themes emerging from the thematic analysis were: *support*, *possibility of choice and feeling in control* and *having appropriate information*. Conversely, healthy outcomes, professional competencies and theoretical knowledge seem to be less important to them than to the midwives. Each theme is now discussed in more depth.

The importance of having a supportive midwife

Dahlen et al. (2010) state that the caregiver's support seems to strongly influence the relationship between women and midwives. The authors explored first-time mothers' experiences of birth at home and in hospital in Australia using a Grounded Theory methodology. The analysis of data showed that women highly valued the supportive presence of their midwives. In relation to the place of birth, home birth midwives appeared to be more supportive due to the trusting relationship they established with the woman, their philosophy of care and their freedom from time restrictions and hospital procedures.

The importance of having a supportive midwife has also been underlined by other authors. Berg et al. (1996) undertook a qualitative study in Sweden using a phenomenological approach with the aim of describing 18 women's experience of the encounter with the midwife during childbirth. The authors identified the recurring theme of being supported by the caregiver. Brown et al. (2009) examined the perspectives of women and their partners ($n=10$) regarding the key roles of the labour and delivery nurse through semi-structured interviews. The caregiver was described as carrying out several important roles, which included support. The participants highlighted the importance of receiving both physical and psychological support.

Tumblin and Simkin (2001) undertook a quantitative study with the objective of determining nulliparous pregnant women's expectations of the labour and delivery nurse's role in a North American setting. The researchers surveyed 57 women, asking them what activities they expected from their nurse during labour and birth. The women listed a total of 174 items. The greatest part of the tasks with a percentage of 29% was related to providing emotional and informational support. The findings from this study are in contrast with two previous quantitative studies where the authors found that labour and delivery nurses spend little time giving women informational support (Mcniven et al., 1992; Gagnon and Waghorn, 1996).

Having choice and feeling in control

The literature review highlights that most women value making informed choices and feeling in control (Green et al., 1990; Tumblin and Simkin, 2001; Dahlen et al., 2010). The themes of choice and control seem to be related and their interdependence is supported by Dahlen et al. (2010).

Green et al. (1990) undertook a large-scale prospective questionnaire survey that included 825 women giving birth in six hospitals in England in 1987. The study was designed to assess the relationships between expectations, experiences and psychological outcomes of birth. The data suggest that having appropriate information and feeling in control were important aspects for the woman's well-being during labour and after the birth.

After noting the lack of knowledge around the topic, Green et al. (2000) undertook further research with the aim of examining changes over time (1987–2000) in women's expectations and experiences of intrapartum care and to relate these to psychological outcomes. The authors paid particular attention to the issues of decision-making, choice and control valued by the *Changing Childbirth* report (Cumberlege et al., 1993). The researchers found that after the *Changing Childbirth* report some changes in women's expectations occurred, mainly in the area of labour pain and decision-making. In fact, women in 2000 were more likely to be anxious about pain in labour and to accept interventions. Green et al. (2000) interpret this as related to the increased use of epidurals and to the diffusion of medicalised models of care. Furthermore, women in 2000 expected and became more involved in non-emergency decision making. In fact, they were more satisfied with the information received than women in 1987. Thus, it could be argued that decision-making and possibility of choice are closely associated with the quality and amount of information that the women received from the caregivers.

Women's expectations may also differ by where they choose to give birth. For example, having a predisposition to interventions and epidural may be more important for those who choose hospital. Thus, planned place of birth can be considered an important influencing factor for childbearing women's expectations. However, women's understanding of the midwife's role have not been investigated in relation to different birth places., there is evidence that women giving birth at home or in birth centres have a more positive experience (Waldenstrom and Nilsson, 1993) and are less likely to regard birth as a medical condition than labour-ward mothers (Cunningham, 1993). Furthermore, Waldenstrom and Nilsson (1993) argue that birth centre care successfully meets the needs of women who are interested in natural childbirth and active involvement in their own care.

Most women seem to value active involvement in the process of care, the possibility of choice and feeling in control during their childbearing event. However, it must be acknowledged that women sometimes prefer to give professionals the authority to make important decisions, placing themselves in the hands of the caregivers. In fact, some women do not want to makes choices, preferring the midwife or the doctor make it for them (Walker et al., 1995).

The issues around the possibility of choice are connected with the area of moral and ethical values of both the woman and the midwife. The question that arises is whether and how the balance between the midwife's support and the woman's choice/control can be addressed. Kennedy (2000: 12) articulates well an ideal balance, by reporting a woman's description about her feeling of

achievement in the process of birth: 'I've never played football, but if I had, giving birth with her was like catching a winning touchdown in the fourth quarter of a game against a rival, feeling tired and sore, but on top of the world'. The key message is that it was the woman who scored the touchdown, not the midwife, but together they were a team that moved toward an identified goal.

The woman values a midwife that gives appropriate information

Having appropriate information is a precursor to women's possibility of choice. As suggested by Dahlen et al. (2010) the provision of information, communicated clearly by the midwife enables the woman to exercise informed choice. Furthermore, giving appropriate information reduces the woman's fears and enables the childbearing woman to feel more confident in her own potential. Midwives are often described by women and their partners as educators, because 'they are there to provide information, to answer questions, to be somebody who has time to discuss things with the couple about the birthing process' (Brown et al., 2009: 328).

Feeling informed by the midwife was valued by the women ($n=32$) that gave birth in a midwife-led unit interviewed by Walker et al. (1995). The participants highlighted the importance of having satisfactory information about what is happening or will happen and how to cope with it. Further, they affirm that this is a fundamental condition for personal control and possibility of choice. The greatest majority of the women that delivered in the unit expressed gratitude at being adequately informed at a personal level throughout their labour. For women whose labour did not develop as expected, this was even more critical. However, it is not clear if the need for information when labour took an unexpected turn was impacted on by a change in the planned place of birth. Walsh (2010) states that childbearing women's experiences of birth are often shaped in the uneasy space between the biomedical model and the more 'natural' approach of the midwife.

Tumblin and Simkin (2001) surveyed 57 women aiming at determining nulliparous pregnant women's expectations of their nurse's role during labour and delivery in North America. Giving information/instructions was the key finding. Women seemed to highly value midwives that answered questions ($n=11$) and helped them with breathing and relaxation techniques. In particular, the results of this study demonstrate that women have clear ideas of the role of the midwife's during labour and birth.

Discussion

Women's perceptions of what is a *good midwife* are pivotal because in many countries the midwife is the woman's primary carer and are therefore likely to have a significant impact on whether a mother is satisfied with her birth experience. However, Lewis (1990: 15) argues that 'there has always been a gap between the perceptions and demands of women in respect to maternity policies and practices, and what has been offered by policy-makers and professionals'. Tumblin and Simkin (2001) claim that fulfilling women's expectations about childbirth can increase women's satisfaction with their birth experiences. Proctor (1998) underlines the importance of understanding the concerns and needs of women by midwives. This is essential in the development of a woman-centered service in line with current statutory regulation (Nursing and Midwifery Council, 2008). Furthermore, it has implications for improving the service quality for those who provide and experience the service.

Since the early 1990s UK government maternity care policy included the aim of providing women with a real possibility of choice regarding the place of birth. To address this, a range of NHS trusts directed initiatives aimed at changing the organisation and delivery of maternity care, moving away from consultant-led care for women with straightforward pregnancy. In this context, midwife-led units and home birth services are becoming increasingly relevant to the configuration of maternity services currently under consideration in UK (Hollowell, 2011). In addition to this, the role of the midwife has undergone a number of changes in recent decades, primarily related to a greater emphasis on woman-centered care.

The literature review reveals information about what is considered to be a *good midwife* from a range of perspectives and what women value in a midwife, but a dearth of information around women's expectations and experiences specifically of a *good midwife*, and even less around whether this changes according to where they give birth.

According to the thematic analysis around what childbearing women value in a midwife during labour and birth, great importance is placed on the relationship with their midwife. In particular, frequent key-themes emerging from the literature were: support, possibility of choice, feeling in control and having appropriate information. Establishing a good and trusting rapport may be a necessary condition for quality midwifery practice. Conversely, professional competencies and theoretical knowledge seem to be less important to women. Given the earlier reflections on what regulatory bodies and what midwives themselves say, there appears to be a mismatch between women and midwives.

Furthermore, important changes in practice and in everyday life (e.g. the birth of internet and modern technologies) have taken place in the period of time this literature review refers to. This might have caused a significant shift in women's expectations about their childbirth experience. In support to this, Green et al. (2000) found that women's expectations changed in a period of thirteen years, from 1987 to 2000. Thus, the exploration of childbearing women's expectation of the *good midwife* will add new knowledge to the existing body of literature.

Women's expectations and experiences of the *good midwife* have not been investigated in relation to different birth settings although this is likely to be an important influencing factor.

In addition to this, most researchers studied women of mixed-parity (nulliparous and multiparous) and few authors considered nulliparous women as a group on their own. However, nulliparous women's experiences are of particular importance as the first birth experience is known to shape future reproductive choices.

Conclusions and implications for practice

The guiding question of this literature review was: who is a *good midwife*? A *good midwife* should possess several attributes: theoretical knowledge, professional competencies, personal qualities, communication skills and moral/ethical values. However, the meaning of *good midwife* might change according to different actors involved in midwifery care and there is no agreement on the definition of what constitutes a *good midwife*. Furthermore, it is not clear if what women value in a *good midwife* corresponds to the midwives' perception of themselves as good professionals. The literature review shows some information about what women value in a midwife, but a dearth of information around nulliparous women's expectations and experiences specifically of a *good midwife* during childbirth in regard to different birth settings.

This literature review seeks to stimulate debate and reflection about the nature of the midwife's role, competencies and qualities among midwives and professionals involved in the childbearing event, in order to fulfil women's expectations of their midwife and increase their satisfaction with the birth experience. The identification of the gaps in the evidence provided the starting point and

allowed the development of research questions and methodology for an ongoing doctoral research. On the basis of the gaps in the evidence, the doctoral research will explore and seek to explain nulliparous women's expectations and experiences of a *good midwife* in the context of different planned place of birth, using a Grounded Theory methodology. It is also expected that the findings of this literature review will stimulate additional research in this area to ultimately inform midwifery practice and midwifery educational programmes.

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