Evaluation of good obstetric practices in the parturition process

Avaliação de boas práticas obstétricas no processo de parturição

Evaluación de buenas prácticas obstétricas en el proceso del parto

RESUMO

Objetivo: analisar as práticas obstétricas no trabalho de parto e parto em uma maternidade de ensino. Método: estudo descritivo, com 150 parturientes de São Luís, Brasil. Aplicado questionário e checklist, entre janeiro e setembro de 2020, dados analisados pela análise descritiva e o teste Exato de Fisher. Resultados: maioria das mulheres entre 20 e 29 anos, ensino fundamental, até 5 consultas de pré-natal e primíparas. As boas práticas obstétricas ofertadas foram: presença de acompanhante (96,0%), amamentação na 1ª hora de vida (94,7%) e contato pele a pele imediato (90,7%). Baixa adesão do uso do partograma (34,0%), a manobra de Kristeller ocorreu (6,0%). Segundo o score de Bologna apenas 11,3% das mulheres foram assistidas com práticas baseadas em evidências. Conclusão: A presença do partograma, a ausência de estimulação do parto e o parto em posição não supina tiveram associação com a assistência baseada em evidências, identificaram-se práticas apoiadas no modelo tecnocrático, requerendo estratégias para promoção de mudanças no modelo obstétrico.

DESCRITORES: Enfermagem; Atenção à Saúde Baseada na Evidência; Humanização da Assistência; Parto Humanizado.

ABSTRACT

Objective: to analyze obstetric practices in labor and delivery in a teaching maternity hospital. Method: descriptive study, with 150 parturients in São Luís, Brazil. A questionnaire and checklist were applied between January and September 2020, data analyzed by descriptive analysis and Fisher's Exact test. Results: most women between 20 and 29 years old, elementary school, up to 5 prenatal consultations and primiparous women. The good obstetric practices offered were: presence of a companion (96.0%), breastfeeding in the 1st hour of life (94.7%) and immediate skin-to-skin contact (90.7%). Low adherence to partogram use (34.0%), Kristeller's maneuver occurred (6.0%). According to the Bologna score, only 11.3% of women were assisted with evidence-based practices. Conclusion: The presence of the partograph, the absence of labor stimulation and delivery in the non-supine position were associated with evidence-based care, practices supported by the technocratic model were identified, requiring strategies to promote changes in the obstetric model.

DESCRIPTORS: Nursing; Evidence-Based Practice; Humanization of Assistance; Humanizing Delivery

RESUMEN

Objetivo: analizar las prácticas obstétricas en trabajo de parto y parto en una maternidad escuela. Método: estudio descriptivo, con 150 parturientas en São Luís, Brasil. Se aplicó cuestionario y lista de cotejo entre enero y septiembre de 2020, datos analizados por análisis descriptivo y prueba Exacta de Fisher. Resultados: la mayoría mujeres entre 20 y 29 años, primaria, hasta 5 consultas prenatales y primíparas. Las buenas prácticas obstétricas ofrecidas fueron: presencia de acompañante (96,0%), lactancia materna en la 1ª hora de vida (94,7%) y contacto piel con piel inmediato (90,7%). Baja adherencia al uso del partograma (34,0%), ocurrió maniobra de Kristeller (6,0%). Según el puntaje de Bolonia, solo el 11,3% de las mujeres fueron asistidas con prácticas basadas en evidencia. Conclusión: La presencia del partograma, la ausencia de estimulación del trabajo de parto y el parto en posición no supina se asociaron a la atención basada en evidencias, se identificaron prácticas sustentadas en el modelo tecnocrático, requiriendo estrategias para promover cambios en el modelo obstétrico.

DESCRIPTORES: Enfermería; Práctica Clínica Basada en la Evidencia; Humanización de la Atención; Parto Humanizado.

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INTRODUÇÃO

The moment of childbirth is very significant in the life of a woman and her baby, being permeated by biological and psychological meanings, it constitutes a critical moment because it is seen as a passage permeated by a feeling of irreversibility, generating anxiety, insecurity and lack of control. [1] The proposal for the humanization of childbirth and birth recognizes the autonomy of women as a human being, and the need to treat this moment with practices that, in fact, have evidence and allow them to increase their safety and well-being, as well as that of the newborn. [2]

In the current scenario, the predominant model of care during labor and birth in Brazil is characterized by the abusive or inappropriate use of interventions and the restriction of the parturient's rights (restriction to the presence of a companion) in the clinical periods of childbirth. Measures that only aim at intervention, often unnecessary, put the life of the binomial at risk. [3]

The emergence of good practices in childbirth and birth was the result of criticism of the harmful consequences of the medicalized model, predominant in obstetric care in Brazil. This care model has been associated with the increase in maternal and infant morbidity and mortality in many countries, characterized by disrespect for the normality of childbirth, and the rights involved in parturition care. In this way, a movement called "humanization of childbirth" was encouraged, with the introduction into the public health system (SUS) of programs that guide women's and newborn's health care, with a view to reducing the rate of unnecessary interventions and , consequently, the rate of avoidable cesarean sections, which is still alarming in the country. [4]

The main objective of good practices is to reduce these unnecessary medical interventions, such as routine oxytocin, restriction of free movement, episiotomy without indication, and Kristeller maneuver, the latter being considered obstetric violence. Good practices are mainly related to light health care technologies, that is, to well-conducted prenatal guidelines, to the reception and the free choice of the woman, as well as the inclusion of the family and/or the companion in the parturition process. It is worth noting that the role of women, and a stronger multidisciplinary team, are also part of the concept of humanization of childbirth care. [2]

In this way, the relevance of the study is characterized by bringing new information to support care based on scientific evidence, giving visibility to good practices in a teaching hospital, in addition to the fact that childbirth and birth care is a topic of international discussion that has made efforts to reduce damage to the puerperal pregnancy cycle. [5]

A dynamic look is needed to implement good practices in childbirth, placing the woman and the baby as protagonists in this process. Therefore, the objective of the research is to analyze the obstetric practices that are developed in a reference obstetric center in the state of Maranhão.

METHOD

Descriptive, exploratory study with a quantitative approach, carried out in a reference maternity hospital for childbirth in the city of São Luís, Maranhão, Brazil. This study is part of a macro-research project entitled: "HUMANIZED ASSISTANCE: evaluation of good practices in the prenatal, delivery and birth scenario in São Luís-MA".

Descriptive, exploratory study with a quantitative approach, carried out in a reference maternity hospital for childbirth in the city of São Luís, Maranhão, Brazil. This study is part of a macro-research project entitled: "HUMANIZED ASSISTANCE: evaluation of good practices in the prenatal, delivery and birth scenario in São Luís-MA".

The calculated sample was 150 parturients. The sample size was based on the estimate of the total number of women with normal deliveries in the 6-month period and the sampling plan used was the simple random sample formula for the known population.

Data collection was carried out between January and September 2020, through a questionnaire and checklist where the medical records, the parturients and the records generated by the maternity's own

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instruments were investigated.

The following independent variables were included in the study: sociodemographic: age group, education, marital status and occupation; obstetrics: number of prenatal consultations, place of consultations, parity and number of previous pregnancies and related to good practices in labor and birth care: use of partogram, presence of a companion, initiation of breastfeeding in the 1st hour after delivery, record of skin-to-skin contact in the 1st hour of the newborn's life, record of the use of non-pharmacological pain relief measures, performance of episiotomy, amniotomy during labor, stimulation of non-supine position during labor and delivery, performance of Kristeller's maneuver, prescription of oxytocin during labor and professional who assisted the delivery.

The outcome dependent variable was "Evidence-based care", created from the Bologna Score, composed of five items: 1) presence of a companion during labor and delivery, 2) use of partogram, 3) lack of stimulation of labor and delivery (use of oxytocin, kristeller maneuver, episiotomy), 4) delivery in a non-supine position and 5) skin-to-skin contact of the mother with the newborn (recommended 30 minutes in the first hour after birth).

A score is awarded for each practice: 1, when present and 0 when absent, the sum of the scores attributed to each practice corresponds to the final result. The maximum score of 5 represents assistance in labor and delivery based on practices based on scientific evidence. [6]

Thus, it considered "care based on scientific evidence" when all practices were found in the care of the mother and child, that is, the score equal to 5 and "care not based on scientific evidence" when the score found was less than 5 .

For data analysis, the Statistical Package for the Social Sciences (SPSS) program, version 19.0 was used. In the univariate analysis, the data were submitted to quantitative descriptive statistical analysis with calculations of absolute and relative frequencies and, in the bivariate analysis, statistical significance was calculated using Fisher's exact test to analyze the association between independent and dependent variables. Considering the statistical significance of the associations when the p value < 0.05 (5%) was obtained.

The research project was approved by the Research Ethics Committee of the University Hospital of the Federal University of Maranhão (CEP-HUUFMA) with opinion number 3,451,855, in compliance with Resolution MS/CNS nº 466/2012 and its complementary ones. For data collection with the parturients, the signing of the Free and Informed Consent Term (FICT) was requested.

RESULTS

According to the characterization of sociodemographic aspects, 75 (50%) were between 20-29 years old, 44 (29.3%) were between 30-40 years old and 31 (20.7%) were between 17-19 years old, 78 (52%) of the women had completed elementary school, more than half 92 (61.3%) without a partner and the majority 121 (80.7%) without occupation (Table 1).

The characterization of the obstetric aspects shows that 75 (50%) performed 1 to 5 prenatal consultations and five (3.3%) did not perform prenatal care, 141 (94%) sought the public service for prenatal care and 60 (40%) were primiparous (Table 2).

In the characterization of good practices of care during labor and birth, the use of a partograph was observed 51 (34%), presence of a companion 144 (96%), initiation of breastfeeding in the 1st hour of the NB's life 142 (94.7%) , record of skin-to-skin contact in the NB's 1st hour of life 136 (90.7%), use of non-pharmacological pain relief measures 76 (50.7%), episiotomy four (2.7%) not justified four (100%). Amniotomy 72 (48%) not justified 72 (100%), non-supine position during labor and delivery 77 (51.3%), Kristeller maneuver nine (6%), prescription of oxytocin in labor 76 (50.7%) not justified 76 (100%). Most deliveries, 141 (94%) were assisted by the medical category (Table 3).

It was identified that 7 (11.3%) of the women received evidence-based care, that is, they were in accordance with score 5,

Table 1 - Sociodemographic aspects of women assisted during childbirth. Sao Luis, MA, Brazil, 2020

Variables	n	%
Age group		
17-19	31	20,7
20-29	75	50
30-40	44	29,3
Education		
Illiterate	18	12
Elementary school	78	52
High School	40	26,7
Superior education	14	9,3
Marital status		
No steady partner	92	61,3
With steady partner	58	38,7
Paid occupation		
Yes	29	19,3
No	121	80,7

Source: Own authorship

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while 133 (88.7%) did not benefit from this model (Table 4).

There is an association between the variables presence of the partograph (p=0.000), absence of stimulation of labor and delivery (p=0.000) and delivery in the non-supine position (p=0.000) with the variable evidence-based assistance. Showing that they were statistically significant at a significance level of 5% (0.05) (Table 5).

DISCUSSION

The study made it possible to trace the sociodemographic and obstetric characteristics and the good practices offered, a fact that may have an impact on the quality of the health of parturients; as well as influencing the success of good practices for the achievement of care based on scientific evidence.

The predominant age group was between 20-29 years of age, followed by 30-40 years and adolescents between 17-19 years. These results are similar to a study carried out in 2018 in Paraná, which found 49.9% in the age group between 21 and 30 years old, 25.6% were 35 years old or older and 24.5% were 19 years old or younger. [7] It is noteworthy that the maternal percentage of adolescents in both studies is above the national study for the year 2017, which was 15.7%. [8]

Indicating the need for family planning strategies for this age group with the aim of reducing maternal mortality, since compared to other women, young adolescents face a higher risk of complications and death as a result of pregnancy. [9]

Most parturients had only elementary education, similar data were found in another study, in which most parturients (48.2%) had elementary education and only 4.1% completed higher education. [10] Low schooling represents an obstetric risk factor as it makes it difficult to understand health education actions. [11]

A significant majority of women declared not having a steady partner. The insecure marital status can be a risk factor for pregnancy due to the possibility of

Table 2 - Obstetric characteristics of women assisted during childbirth. São Luís, MA, Brazil, 2020

Variables	Nº	%
Number of prenatal consultations		
Did not perform prenatal	5	3,3
1 to 5 consultations	75	50
6 consultations or more	70	46,7
Place of consultations		
Public service	141	94
Private service	4	2,7
Parity		
Primiparous	60	40
Secondiparous	51	34
Multiparous	39	26

Source: Own authorship

Table 3 - Good practices in assisting women during childbirth. São Luís, MA, Brazil, 2020

Variables	Yes		No	
	n	%	n	%
Use of partogram	51	34	99	66
Presence of the Companion	144	96	6	4
Breastfeeding in the newborn's 1st hour of life	142	94,7	8	5,3
Skin-to-skin contact in the 1st hour of life	136	90,7	14	9,3
Non-pharmacological pain relief measures	76	50,7	74	49,3
Performing an episiotomy	4	2,7	146	97,3
Amniotomy during labor	72	48	78	52
Non-supine position during labor and delivery	77	51,3	73	48,7
Kristeller Maneuver	9	6	141	94
Oxytocin during labor	76	50,7	74	49,3
Childbirth assisted by a medical professional	141	94	9	6
Childbirth assisted by a professional nurse	9	6	141	94

Source: Own authorship

Table 4 - Bologna Score for construction of the outcome Care Based on Scientific Evidence. São Luís, MA, Brazil, 2020

Score	n	%
0	-	-
1	5	3.4
2	29	19,3
3	63	42
4	36	24
5 (EBA)*	17	11,3
Total	150	100

*Evidence-Based Assistance
Source: Own authorship

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affecting the psychological situation and maternal economic stability. [12]

There was a high percentage of women who reported not having remuneration, a fact that may be related to the low level of education found, as this facilitates access to employment and better socioeconomic conditions. [13]

In this study, most pregnant women did not have at least 6 prenatal consultations as recommended by the Ministry of Health. [14] Several authors emphasize that well-structured prenatal care can promote the reduction of premature births and unnecessary cesarean sections, of children with low birth weight, of complications of arterial hypertension during pregnancy, of vertical transmission of pathologies such as HIV, syphilis and hepatitis, in addition to favoring adherence to good labor and birth practices. [15-17]

The public service was the most used for prenatal care. Prenatal care is a typical programmatic action of primary care, where the actions of qualification of the teams and of the work processes have a fundamental role in improving the care of the baby and the pregnant woman. [18]

Primiparous parturients predominated, drawing attention to the importance of the experience of this moment, which may reflect on the woman's experience in the parturition process. The study of care practices for normal childbirth: the experience of primiparous women brought as a conclusion the need to rethink and reformulate institutional care practices that are in disuse and to invest in continuing education and in the practice of care that contribute to the physiological evolution of childbirth. [19]

As for good practices in childbirth and birth care, little adherence to the use of the partogram was observed. The partogram is an instrument that allows the graphic visualization of the evolution of work and should be used in the care of all parturients, guiding the obstetric procedures used. [20-22]

The presence of a companion was effective, a divergent result from another study showed that only 42% of postpartum women had the presence of a companion of their choice during delivery and the most frequent reason for being unaccompanied was the team's refusal to accept the companion. [23]

Table 5 - Association of good practice variables according to the outcome variable Care based on scientific evidence. São Luís, MA, Brazil, 2020

PRACTICES	EBA				p-value*
	Yes		No		
	n	%	n	%	
Presence of a companion during childbirth					
Yes	127	88,2	17	11,8	1,000
No	6	100		-	
Use of partogram					
Yes	34	66,7	17	33,3	0,000
No	99	100		-	
Absence of stimulation of labor and delivery (oxytocin, Kristeller maneuver and episiotomy)					
Yes	56	76,7	17	23,3	0,000
No	77	100		-	
Delivery in non-supine position					
Yes	60	77,9	17	22,1	0,000
No	73	100		-	
Skin to skin contact					
Yes	119	87,5	17	12,5	0,369
No	14	100		-	

* Fisher's Exact Test
Source: Own authorship

Early skin-to-skin contact between mother and baby proved to be a consolidated practice and is important because it psychologically stimulates mother and baby to get to know each other, after birth babies are colonized by microorganisms; it is best that they come into contact with their mothers' skin flora, and not be colonized by bacteria from service providers or a hospital. [21]

Encouraging early breastfeeding was a good practice present in the assistance to postpartum women. Among the benefits that breastfeeding brings to the baby are the ease of eliminating meconium, protects the gastrointestinal tract against infections, promotes attachment, decreases the risk of jaundice, and reduces infant mortality rates. [20,24,25]

Non-pharmacological methods of pain relief were offered to most women. Studies emphasize that non-pharmacological methods should be offered from admission for better management of labor and better perinatal outcomes. [20,21,24]

The stimulus to the upright position in labor and delivery was present for the most part. This practice helps to avoid a decrease in the effectiveness of uterine contractions due to the compression of large blood vessels by the uterus, which makes gas exchange between mother and fetus difficult and reduces the duration of delivery, often avoiding obstetric interventions that cause pain and discomfort. [24,26]

Episiotomy, amniotomy and administration of oxytocin in labor are practices that should not be used routinely and, when used, should be limited to strictly necessary and duly justified cases. [20,21,24] In the present study, these practices were identified, however, there was no justification for carrying them out, which constitutes practices of inappropriate use, drawing attention to amniotomy that occurred very frequently.

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In this study, the Kristeller maneuver was recorded in some deliveries. The Kristeller maneuver is considered a clearly harmful practice, and can cause serious injuries, such as placental displacement, rib fractures and brain trauma. [20,21,26]

The nurse had his assistance recorded on the birth record in the minority of cases. In the parturition process, the MH encourages nurses to act as a good practice in childbirth and birth care, regulated by the Federal Nursing Council (COFEN), in normal delivery care, without dystocia. [2,15,27]

The Bologna score encompasses the practices considered essential for the provision of adequate care during childbirth, that is, based on evidence. The present study showed that a small number of women benefited from care based on scientific evidence, meeting the criteria related to the presence of a companion, use of the partogram, absence of labor stimulation, delivery in a non-supine position and skin-to-skin contact of the mother with the newborn. A study carried out in Natal showed similar data, concluding that it is necessary to improve and readjust the current obstetric model. [28]

The study showed an association of the partogram with scientific evidence in obstetric care. In labor care, the correct use of the partogram is a practice that requires low-complexity training, being a simple and inexpensive tool, but which can have a great beneficial impact, especially in this transition from obstetric care models. [21]

In this study, the use of oxytocin, Kristeller's maneuver and episiotomy was observed, without due justification. According to evidence-based care, these practices can be justified when they reflect on the quality of care offered and on the obstetric outcome. The use of oxytocin must occur in a way that its effects can be controlled by the risks of uterine rupture and fetal distress, Kristeller's maneuver is not a recommended practice and can be related to maternal and fetal injuries and episiotomy is a practice that requires disuse as it is one of the most frequent causes of maternal morbidity. [18,24]

In some studies, the interventionist culture that treats women as a voiceless individual at the time of childbirth shows the feeling of fear, discomfort and insecurity. When there is conduct based on good practices, there is also a greater participation of women in this process, allowing them to be part of the decisions, in order to place them as protagonists. By basing the conduct on humanization, care becomes respectful and dignified, resulting in the reduction of proscribed and harmful conduct. [29]

Regarding the relationship evidenced in the study of childbirth in the non-supine position with evidence-based care, this is a good practice that, although not yet a constant, the occurrence of deliveries in this position was observed. The non-supine position is considered a good practice, due to the fact that vertical positions reduce the time of labor, the lower probability of cesarean section, less need for pharmacological analgesia, and fewer admissions to neonatal ICUs. [30]

Practices based on the humanized model were found in the perspective of practice based on scientific evidence according to what the Bologna score proposes, but practices based on the technocratic model were still revealed.

CONCLUSION

The study revealed that practices supported by the humanized model were found in the perspective of practice based on scientific evidence, reflecting the commitment of the team that integrates the care of childbirth and birth of the evaluated institution, however, practices based on the technocratic model were still revealed. The practices of companion presence, breastfeeding and skin-to-skin contact in the 1st hour of life, use of non-pharmacological pain relief measures and stimulation of the non-supine position in labor and delivery were offered to most parturients. While the practice of using the partograph should be encouraged, episiotomy, amniotomy and the administration of oxytocin in labor need to be justified for use.

Evidence-based care revealed that a minority of women benefited from such a model, leading to a reflection on the need for new research in search of understanding the failure to carry out practices with evidence. The research can provide subsidies for the planning of a more humanized assistance to women in the parturition process, subsidizing actions to qualify obstetric and neonatal care with a view to achieving government proposals and the SDGs, with a consequent reduction in avoidable maternal and neonatal deaths.

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