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Practices in childbirth care in maternity with inclusion of obstetric nurses in Belo Horizonte, Minas Gerais

Práticas na assistência ao parto em maternidades com inserção de enfermeiras obstétricas, em Belo Horizonte, Minas Gerais

Prácticas de atención al parto en maternidades con inclusión de enfermeras obstetras en maternidades de Belo Horizonte, Minas Gerais

Ana Maria Magalhães Sousa[1]
Kleyde Ventura de Souza[1]
Edna Maria Rezende[1]
Eunice Francisca Martins[1]
Deise Campos[2]
Sônia Lansky[3]

1. Universidade Federal de Minas Gerais. Belo Horizonte, MG, Brazil.
2. Fundação Hospitalar do Estado de Minas Gerais. Belo Horizonte, MG, Brazil.
3. Secretaria Municipal de Saúde de Belo Horizonte. Belo Horizonte, MG, Brazil.

Abstract

Objective: To discuss practices in childbirth care in health institutions where doctors and obstetric nurses act together. **Methods:** Cross-sectional study, which had as data source the survey *Born in Belo Horizonte: a survey about delivery and birth*, conducted between 2011 and 2013. The sample consisted of 230 and 238 mothers for practices in childbirth labor and delivery, respectively. The analysis was given by absolute and relative frequencies. **Results:** Useful practices: oral diet (54.6%); freedom of movement (96%); non-pharmacological methods of pain relief (74.2%); companion (95.4%); partogram (77.4%). Harmful practices: enema (0); trichotomy (0); lying position (66.8%); Kristeller (9.3%). Practices used inappropriately: amniotomy (67.1%); oxytocin (41.7%); analgesia (14%), episiotomy (8.4%). **Conclusion:** Even in institutions engaged in changing the model of obstetric care, it was identified practices that reproduce the technocratic model. The transition of the model of obstetric care remains a challenge, which requires efforts from managers and health professionals.

Keywords: Obstetrical nursing; Childbirth labor; Humanized delivery; Humanization of assistance.

Resumo

Objetivo: Discutir práticas na assistência ao parto em instituições de saúde, onde atuam conjuntamente médicos e enfermeiras obstétricas. **Métodos:** Estudo transversal que teve como fonte de dados a pesquisa *Nascer em Belo Horizonte: um inquérito sobre parto e nascimento*, realizada entre 2011 e 2013. A amostra foi de 230 e 238 puérperas para práticas no trabalho de parto e parto, respectivamente. A análise deu-se mediante frequências absoluta e relativa. **Resultados:** Práticas úteis: dieta oral (54,6%), livre movimentação (96%), métodos não farmacológicos para dor (74,2%), acompanhante (95,4%), partograma (77,4%); práticas prejudiciais: enema (0), tricotomia (0), posição deitada (66,8%), Kristeller (9,3%); práticas usadas inapropriadamente: amniotomia (67,1%), ocitocina (41,7%), analgesia (14%), episiotomia (8,4%). **Conclusão:** Mesmo em instituições que se empenham na mudança do modelo de atenção obstétrica, identificaram-se práticas que reproduzem o modelo tecnocrático. A transformação do modelo de assistência permanece um desafio que requer esforços conjuntos de gestores e profissionais de saúde.

Palavras-chave: Enfermagem obstétrica; Trabalho de parto; Parto humanizado; Humanização da assistência.

Resumen

Objetivo: Discutir prácticas de atención al parto en instituciones de salud donde médicos y enfermeras obstetras trabajan conjuntamente. **Métodos:** Estudio transversal cuya fuente de datos fue la investigación *Nacer en Belo Horizonte: un estudio de parto y nacimiento*, realizada entre 2011 y 2013. Se estudiaron 230 y 238 mujeres para prácticas en el trabajo de parto y parto, respectivamente. El análisis estuvo a cargo de frecuencias absolutas y relativas. **Resultados:** Prácticas útiles: dieta oral (54,6%); libre circulación (96%); métodos no farmacológicos para el dolor (74,2%); acompañante (95,4%); partograma (77,4%). Prácticas perjudiciales: enema (0); tricotomía (0); acostado (66,8%); Kristeller (9,3%). Prácticas inadecuadas: amniotomía (67,1%); oxitocina (41,7%); analgesia (14%); episiotomía (8,4%). **Conclusión:** Mismo en las instituciones que se esmeran por cambiar el modelo de atención obstétrica, se identificaron prácticas que reproducen el modelo tecnocrático. La transformación de ese modelo permanece un desafío que requiere esfuerzos conjuntos entre gerentes y profesionales de salud.

Palabras clave: Enfermería obstétrica; Trabajo de parto; Parto humanizado; Humanización de la atención.

Corresponding author:
Kleyde Ventura de Souza.
Email: kleydeventura@gmail.com

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INTRODUCTION

In Brazil, it is noted, at present, what can be called a transitional movement of assistance model of parturition and birth. The focus of change begins from a model that considers the delivery a medical and risk event, whose scenario is the hospital environment. At the expense of care centered on the woman, on her role and autonomy, this model, named by Davis-Floyd[1] technocratic, is marked by unnecessary and harmful interventions that result in high rates of Caesarean sections, and considers birth a pathological event that needs to be treated.

In this context, from the 1980s, the movement of childbirth humanization became visible, which in addition to the warm and respectful care for women during labor, proposed assistance based on scientific evidences, one of the most important marks of the transition to change the Brazilian obstetrical care model. Obstetrical practice based on evidences described by the World Health Organization[2] and later ratified by the Ministry of Health[3] is based on the classification of obstetric behavior in normal birth from scientific evidence, according to criteria of usefulness, effectiveness and risk. These recommendations have led to the categories of practices used in normal childbirth assistance: category A - demonstrably useful practices and that should be encouraged; category B - clearly harmful practices or ineffective and that should be eliminated; category C - practices in which there is no evidence to support its recommendation and that should be used with caution until further research clarify the issue; category D - practices that are often used improperly[2].

These documents also emphasize the obstetric nurse as an essential component of humanized delivery care. There is evidence in international scientific studies regarding the improvement of the quality on childbirth care after the presence of these professionals, as well as reduced risk of interventions such as episiotomy and instrumental delivery, providing more sense of control of the birth experience for women[4].

In Brazil, some experiences of institutions that seek integrated work between nurses and doctors in birth assistance have been implemented as institutional policies, strengthening public policies until then formulated. However, the efficiency and effectiveness of these services with emphasis on the practice of the professionals working in this perspective are not yet known in a systematic way.

In this context, the objective of this study was to discuss the assistance practice in childbirth labor and delivery in maternities with insertion of obstetric nurses.

METHODS

This is a cross-sectional study which used information from the database of the survey *Born in Belo Horizonte: a survey about delivery and birth*, held on 11 maternity hospitals in Belo Horizonte, Minas Gerais - MG. This survey was representative for the local population of the municipality and employed the same method, logistic and material resources of a nationwide study entitled *Born in Brazil: a survey about delivery and birth*, in which were included all Brazilian state capitals, including Belo Horizonte.

For the purposes of this study, two health institutions included in the research developed in Belo Horizonte were selected, in which parturition assistance and birth are performed by doctors and obstetrics nurses. These institutions are located in the districts Norte and Venda Nova and assist women exclusively by the Unified Health System ("SUS").

In one of the institutions, the data collection occurred between the months of May and July of 2011; and in another, in July of 2012, performed by previously trained nurses. Interviews were conducted with recent mothers during their hospitalization at least 6 hours after birth. Data from maternal and newborn medical records were obtained after the discharge or death. Recent mothers who did not understand the Portuguese language, indigenous, mentally handicapped, deaf-mute, homeless and condemned by court order were excluded. Further information about the data collection process, logistics and field characteristics of the questionnaires are available in previously published study[5].

The population of the two hospitals scenarios of this study, therefore, was 312 women selected on the occasion of the holding of birth and their concepts, dead or alive, with birth weight ≥ 1.102 lb and/or gestational age ≥ 22 weeks of gestation. Given the specificity of practices in each of the stages of the parturition process, data on obstetric practices were organized into two distinct groups: the practical assistance to childbirth labor and practices in the deliveries.

For the evaluation of obstetrical practices performed during childbirth labor, were included only women who had valid responses to the spontaneous or induced labor experience, in both questionnaires (interviews and medical form). In this way, the final study population practice at that stage was 230 recent mothers. To the practices carried out at the moment of delivery, women submitted to cesarean section were excluded (n = 67), in addition to those without information on the mode of delivery (n = 05), totaling 238 women in this population. There was, however, variation between the practices in function of dubious data both for the practices in childbirth labor and delivery practices.

The variables of interest in this study were obstetric practices used in childbirth labor and delivery. This information was obtained from the questionnaire applied to the recent mothers and also by consulting the patient maternal form, and organized into three categories: demonstrably useful practices; clearly harmful practices and practices often used inappropriately in labor, according to WHO[2] recommendations and Ministry of Health[3] (Box 1).

Box 1. Classification of obstetric practices during childbirth labor and delivery

Categories	Obstetric practices during childbirth labor and delivery (yes/no)
Demonstrably useful practices	- Oral diet offered
	- Freedom of movement and position
	- Non-Pharmacological methods for pain relief
	- Presence of an escort
	- Use of partogram
Clearly harmful practices	- Enema
	- Trichotomy
	- "Lying on back with legs raised" position
	- Kristeller maneuver
Practices often used inappropriately	- Amniotomy
	- Infusion of oxytocin
	- Analgesia
	- Episiotomy

Statistical analysis was given by the average calculation and standard deviation for continuous variables, absolute and relative frequencies for categorical variables and was made with the assistance of the statistical package Stata MP/12.0.

This study had a favorable opinion of the Research Ethics Committee of Universidade Federal de Minas Gerais, under Protocol CAAE-0246.0.203.000-11, and Ethics Committees of the institutions involved.

RESULTS

The sociodemographic characteristics of the participants of this study are similar among women included in the analysis of obstetric practices in labor and those included in the analysis of practices in childbirth. It was observed in both groups, that the age of the recent mothers ranged from 14 to 42 years, predominant age range was 20-29 years. The average age in both groups was 25.4 years (± 6.0) and 25.3 (± 5.9), respectively. More than half of these mothers attended to some of the high school series and less than 4.0% of them came to higher education. The majority reported having a stable union, not having remunerated occupation and not be head of the household, and in relation to the color of the skin, being brown/brunette/mulatto (data not shown in table).

Table 1 shows the obstetric practices used in assisting childbirth labor. The analysis of practices clearly useful and that should be encouraged revealed that freedom of position and movement during childbirth labor and the presence of a companion were respected by the professionals from the institutions studied in more than 95% of women. The use of non-pharmacological methods of pain relief during labor and delivery occurred in 74% of mothers and the monitoring of its progress through the partogram happened in just over 77% of them. Oral diet was offered during labor only to 55.2% of women.

As for the clearly harmful or ineffective practices and that should be eliminated, it was found that the use of enema and trichotomy were not prescribed to women assisted in the institutions included in this study (data not presented in table).

Among the practices often used inappropriately during the first stage of labor, it was found that the amniotomy was performed in 67.1% of women who got into childbirth labor, hospitalized with intact membranes. The prevalence of women who received oxytocin infusion during labor was 41.7%; and 14.0% of women had analgesia in parturition (Table 1).

Of the 238 women who had vaginal births, more than 71.6% were assisted by obstetric nurses, against 28.4% assisted by doctors, and in five of those deliveries forceps was used.

Among the clearly harmful practices at the moment of delivery, were found the Kristeller maneuver (9.3%) and the position "lying on back with legs raised" for childbirth (66.8%). The episiotomy was performed in 8.4% of women (Table 2).

DISCUSSION

Practices demonstrably useful and that should be encouraged during childbirth labor

The results of this study demonstrate the appropriation, by professionals of the health institutions included in this research, of practices demonstrably useful and encouraged during childbirth labor, such as freedom of movement, use of non-pharmacological methods of pain relief and use of the partogram. Clearly harmful practices, such as enema and trichotomy, were not observed,

Table 1. Obstetrical practices demonstrably useful and inappropriate in labor - Belo Horizonte, MG, Brazil, 2011

Obstetrical practices in childbirth labor	n	n	%
Demonstrably useful			
Oral diet offered	229		
Yes		125	54.6
No		104	45.4
Freedom of movement and position	227		
Yes		218	96.0
No		09	4.0
Non-Pharmacological methods for pain relief	229		
Yes		170	74.2
No		59	25.8
Presence of an escort	218		
Yes		208	95.4
No		10	4.6
Partogram	230		
Yes		178	77.4
No		52	22.6
Inappropriate			
Amniotomy	164		
Yes		110	67.1
No		54	32.9
Infusion of oxytocin	230		
Yes		96	41.7
No		134	58.3
Analgesia	229		
Yes		32	14.0
No		197	86.0

Table 2. Obstetric practices clearly prejudicial and inappropriate in childbirth - Belo Horizonte, MG, Brazil, 2011

Obstetric practices in childbirth	N	n	%
Clearly prejudicial practices			
Kristeller maneuver	237		
Yes		22	9.3
No		215	90.7
"Lying on back with legs raised" position	238		
Yes		159	66.8
No		79	33.2
Inappropriate			
Episiotomy	238		
Yes		20	8.4
No		218	91.6

which indicate its elimination of care provided to women studied. However, interventionist practices such as amniotomy, oxytocin infusion and analgesia, are also aggregated to the assistance of these professionals.

Recent nationwide studies have shown that the Brazilian reality still calls for the incorporation of obstetric practice on assistance in childbirth labor, such as: oral diet offer (25.2%); freedom of movement and position (44.3%); use of non-invasive and non-pharmacological methods of pain relief (26.7%); continuous presence of an escort chosen by the woman (18.8%); and monitoring the progress of delivery by using the partogram (41.4%)[6,7].

The benefits of moving the mother during childbirth labor are supported by scientific evidence[8], and in this study the freedom to walk and move around was preserved in number almost three times higher than in recent similar study (29.8%)[9]. Research conducted in different periods have revealed important changes regarding the practice of walking. Between 1998 and 2001, studies that assume the centrality of the doctor in childbirth assistance stressed that only 11.4 to 20.4% of pregnant women had permission to walk[10,11]. Between 2003 and 2007, it was showed the participation of the obstetric nurse in attendance, with rates between 47.6 and 56.2% of use of this practice[12,13].

Almost all the women of this research remained with the companion of their choice during the hospitalization period, results similar to those found in a study conducted in a Normal Childbirth Center ("CPN")[13].

The similarity of these findings with those found in "CPN", considered facilitators spaces for performing practices in accordance with the recommendations of WHO and Ministry of Health[14,15], has made sure that the policy established in institutions included in this work guarantees compliance, in large part, to a practice based on scientific evidence and also to woman's rights which are guaranteed by law in Brazil since 2005[16].

Corroborating other studies, the partogram was used for most pregnant women[11,15]. In Goiânia, the partogram in the medical forms of recent mothers was only 28.5%, and in 13% of cases there was no note[17]. Similarly, it has been found considerable number of incorrect use of the instrument (77.3%), although it was found in almost 80% of patient records[15]. Improper observations can increase more than twice the rate of Cesarean sections, when the partogram is started in the latent stage of the labor[18]. Therefore, the importance of appropriate filling of this instrument is highlighted, assessment not performed in this study.

From this work, the use of non-pharmacological methods of pain relief during labor reinforces the concern of health

professionals involved in providing comfort and support to the women in the moment of pain. Women's satisfaction with their birth is not related only to the absence of pain, but the conditions offered to their confrontation. The effects of supporting women are associated with the duration of labor, the reduction of Cesarean sections and instrumental vaginal deliveries, the use of intrapartum analgesia and better Apgar scores in the fifth minute[19].

In relation to the provision of oral diet during the childbirth labor, although twice as prevalent when compared to national survey[6], similar to other studies[20], more than half of the women fed during this period of confinement. In São Paulo, the majority of women assisted in "CPN" peri-hospitatar (99.7%) or in hospitals (86.7%), had free diet prescription[21].

Practices clearly harmful or ineffective and that should be eliminated from labor

The findings not found, in both evaluated services, unnecessary interventions practices as the use of enema and trichotomy, in contrast to the results of other studies in which, even in the face of scientific evidences[22,23], enteroclysis and shaving were prescribed, respectively, 2.8 and 41.1% of pregnant women assisted by medical institutions in Goiânia[17].

In this research, the amniotomy was performed in more than 65% of pregnant women, in agreement with other studies that, even in "CPN", also found a high proportion of this practice[13,9]. On the other hand, in a municipal maternity in Rio de Janeiro, where the childbirth assistance is also offered for obstetric nurses, amniotomy was held in only 5.8% of women in labor[24].

The acceleration of labor, whether with amniotomy and/or oxytocin, plays an important role in the "cascade of interventions" and in reducing the spontaneous delivery rate. In this study, as well as amniotomy, it was also frequent the use of intrapartum oxytocin. The prevalence of these practices was even higher than that observed in the nationwide search[6]. High levels have also been reported in recent studies conducted in a municipal maternity of Rio de Janeiro (55.5%)[24] and a "CPN" in São Paulo (54%)[9]. In Belo Horizonte, comparing delivery care in three distinct SUS care models, it also considered high the oxytocin administration in all institutions, although it has been less frequent in the "CPN" (27.9%). In the other two modes, a hospital winner of the Galba de Araujo Award and another with the traditional model, the rates were 59.5 and 40.1%, respectively[25].

It is noticeable that the indiscriminate use of oxytocin is present both in hospitals and in the "CPN". This occurrence may reflect the strong influence of the technocratic model about the practices of professionals, among them obstetric nurses because they reproduce, in part, an interventionist assistance. It is believed that the permanence of these interventionist practices in environments where there is the action of obstetric nurses also suffer influence of medical autonomy, since they are the doctors who prescribe medicines, among them oxytocin.

Synthetic oxytocin can correct changes in the evolution of labor, however, has a high risk of damage to the mother and fetus[26,27]. Its use without appropriate monitoring constitutes a dangerous practice, so it was added to the high alert drug list of the Institute for Safe Medication Practice in the United States[28] and its use is recommended with the minimum frequency possible.

The occurrence of analgesia in women of this study was higher than the rates observed in public hospitals in Goiânia (7.7%) and international study (16%)[17,29] and lower than the prevalence of this procedure found in national study (33.9%) - about two times lower[6]. It is also below the recommendation of the use of analgesia in 30% of normal deliveries, when depleted the non-pharmacological resources for pain relief contained in the Commitment Agreement of Maternities of SUS-BH and Management Agreement, established by the Perinatal Committee of the Municipal Health Secretariat of Belo Horizonte (SEMSA-BH) as one of quality of care indicators. This document formalized the agreement of the institutions involved in the implementation of good obstetric practices, including those that are part of this study.

A less selective provision of analgesia for women assisted in the locations studied, accompanied by information about the advantages and disadvantages of this procedure, should be considered as a practice that contributes to the humanization of childbirth. In the case of this study, it can infer that the availability of care practices based on the principles of humanization may have decreased the demand for analgesia in both institutions studied.

From this investigation, almost 67% of women gave birth "lying on back with legs raised". Although this description refers to the lithotomy position, the use of leggings for the leg support has not been identified in the interviews with these women and is known to the researchers, through interviews with the manager about the structure of the institution, that there is no such device in these health services. Data from this study, however, did not identify if at the time of delivery the reclining position was established as the women's choice or whether health professionals nominated it.

However, it is necessary to consider that the lying position is still culturally accepted as suitable for delivery, not only by health professionals but also by women themselves. In Brazil, more than 90% of women still have their children in this position[6]. Nevertheless, findings that indicate appropriation of non-lithotomy positions in childbirth in health institutions in the country were found and indicate the adoption of vertical position for women in labor, especially in births assisted by obstetric nurses (50.6%; 77.8%)[30,24]. In a "CPN" of São Paulo, only 13% of parturitions were assisted in horizontal position, against 77.6% assisted in vertical position[9].

Reinforcing the importance of stimulation of non-lithotomy positions, qualitative study showed that, in addition to scientific evidence arising from clinical trials and systematic reviews on

the subject[31], the recent mothers also realize how beneficial the adoption of the vertical position for childbirth is, because it is more comfortable, favors the movement and the participation of the woman in labor and reduces the expulsive effort[32]. Certainly, the mothers will adopt different positions when there is stimulation, especially of those who watch.

The use of Kristeller maneuver was identified in this study in 9.3% of women. Commonly used in situations such as fetal distress, lack of progress of childbirth and maternal exhaustion, this maneuver offers potential risks that should be considered[33]. In this way, the reports of these women denounce the conservation of a harmful practice that, as it should not be practiced, is invisible to the medical records, as are the reasons for its use. This unnecessary and risky behavior can be considered a violation of the woman's right to bodily integrity, since, in addition to the exposure to risks, causes the discomfort of pain for the mothers during their implementation.

In the nationwide study, around 36% of women reported having been subjected to Kristeller maneuver[6]. These data reflect the spread of this maneuver in the Brazilian obstetric culture and the difficulty of change in professionals' behavior, even in institutions that try to adopt obstetric practices based on evidence, as is the case of the institutions studied. Reinforces the importance of the involvement of institutions that provide delivery assistance in the restructuring of its services, as well as in the qualification of its professionals to reform old concepts and to improve the quality of care provided to users.

Practices often used inappropriately during childbirth labor and delivery

The episiotomy rate in this study was less than half of that proposal in the term sheet of the maternity of SUS-BH, in which the suggested value is about 20%. Although for many years the data available in the literature show that, this procedure does not meet the objectives that justify its conduct routinely, whether injury prevention in mother's genitals or in the newborn's head, still today the episiotomy remains being used improperly in many health institutions.

In studies carried out in Brazilian health services between 1998 and 2007, the rate of this procedure remained between 54.9% and 89.99%[10,25,34-36] in establishments where the deliveries were assisted exclusively by doctors. International Studies, between 1997 and 2007, with the participation of these same professionals in childbirth assistance showed that episiotomy rates ranged from 04 to 100%[37,38]. In the United States, alone, the study showed a decreasing of 60.9% in 1979 to 24.5% in 2004[39].

The data found in national research characterize a technocratic model of care and reveal, even today, the prevalence of this practice on childbirth assistance in Brazil's health services (56%)[6]. In contrast, researches have shown that episiotomy has been applied more carefully at some institutions, especially when there are exclusive or majority participation of obstetric nurses in childbirth assistance. In these studies, conducted between 2001 and 2008, the episiotomy ranged between 16.1 and 31.45%[9,13,24,30,40], indexes, however, still considerably higher than those of this study, which was 8.4%.

CONCLUSION

The results revealed commitment of teams that integrate the labor and birth assistance of the institutions evaluated to emphasizing the humanized assistance and use of practices based on scientific evidences. Practices supported in the humanized model were highlighted, such as the right to have a companion, freedom of movement and position, the use of non-pharmacological methods of pain relief and the use of partogram. The extinction of enema and trichotomy in these institutions, as well as the low prevalence of episiotomy, showed, once again, consonance with the recommendations of WHO and Ministry of Health.

On the other hand, although it also stimulated by WHO and Ministry of Health, it was given less importance to the provision of oral diet during labor. Other practices based on the technocratic model were revealed: amniotomy, use of oxytocin in childbirth labor, the use of Kristeller maneuver and lying position at time of delivery.

The results showed also the incisive participation of obstetric nurses in childbirth labor assistance, delivery and birth in the studied scenarios. The predominance of these professionals in maternity care strengthens its important contribution with regard to the care practice, in accordance with the WHO, the Ministry of Health and the principles of humanization. At the same time, it suggests that they have a significant impact when certain obstetric practices are respected or not.

It is believed that even in institutions that support the insertion of obstetric nurses in childbirth care and birth, the transformation of the healthcare model is still a challenge and requires efforts of managers, health professionals and society. Particularly, in relation to the inclusion of obstetric nurses, are essential institutional support, commitment of managers with public policies, qualified and autonomous training consistent with their role in changing the model and activities committed to the ethical and legal principles of the profession.

It is proposed that the evaluation of the quality of care should not be guided solely by compliance with demonstrably useful obstetric practices and recommended by international and national organizations. Therefore, the importance of studies geared to meet the satisfaction of women and/or its centrality as the care provided to them in childbirth assistance is highlighted. In addition, it needs to have visibility the aspects hidden in the relations between the professional disciplines of nursing and medicine in the context of the obstetric care, from the perspective

of paradigmatic changes, such as the gender and class issues, the condition of women in society - the woman-mother and the woman-nurse. Also others circumscribed to vocational training, procedures of work and management and the quality of interpersonal relationships.

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