Cogitare Enfermagem

ORIGINAL ARTICLE

PICTURE OF MIDWIFERY PRACTICES AT A PUBLIC MATERNITY HOSPITAL

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ABSTRACT
Objective: identify the midwifery practices adopted during delivery and birth care.
Method: cross-sectional, analytic study, undertaken at a public maternity in Aracaju - Sergipe, between November 2015 and February 2016, involving 373 postpartum women with gestational age ≥ 37 weeks, who experienced at least 30 minutes of prepartum. The chi-squared and Fisher's exact test were applied.
Results: the following level A midwifery practices were offered: lukewarm bath 109 (29.2%), massage 62 (16.6%), Swiss ball 50 (13.4%), walking 223 (59.8%), skin-to-skin contact 250 (66.7%) and the presence of a companion 89 (23.9%). Level B and D practices were executed, such as oxytocin 236 (63.3%), amniotomy 171 (45.8%), episiotomy 51 (19.8%) and Kristeller's 129 (34.6%).
Conclusion: this study reveals the need to adapt the ambience and implement the best practices unrestrictedly in order to guarantee safe delivery and birth care and to contribute to the training of new professionals.

DESCRIPTORS: Healthcare; Humanized birth; Professional practice; Maternal-infant nursing; Obstetric nursing.

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RETRATO DAS PRÁTICAS OBSTÉTRICAS EM UMA MATERNIDADE PÚBLICA

RESUMO
Objetivo: identificar as práticas obstétricas adotadas durante a assistência ao parto e nascimento.
Método: estudo transversal, analítico, realizado em uma maternidade pública em Aracaju - Sergipe, no período de novembro de 2015 a fevereiro de 2016, com 373 puérperas com idade gestacional ≥ 37 semanas, que permaneciam no mínimo 30 minutos em pré-parto. Foram utilizados os testes qui-quadrado e exato de Fisher.
Resultados: as práticas obstétricas de nível "A" ofertadas foram: banho morno 109 (29,2%), massagem 62 (16,6%), bola suíça 50 (13,4%), deambulação 223 (59,8%), contato pele a pele 250 (66,7%) e a presença de acompanhante 89 (23,9%). Foram realizadas práticas nível "B e D" como ocitocina 236 (63,3%), aminiotomia 171 (45,8%), episiotomia 51 (19,8%) e Kristeller 129 (34,6%).
Conclusão: este estudo revela a necessidade de adequação da ambiência e implementação irrestrita das boas práticas para garantir assistência segura ao parto e nascimento, assim como contribuir na formação dos novos profissionais.
DESCRITORES: Assistência à saúde; Parto humanizado; Prática profissional; Enfermagem materno-infantil; Enfermagem obstétrica.

RETRATO DE LAS PRÁCTICAS OBSTÉTRICAS EN UNA MATERNIDAD PÚBLICA

RESUMEN:
Objetivo: identificar las prácticas obstétricas adoptadas durante la atención al parto y nacimiento.
Método: estudio trasversal, analítico, desarrollado en una maternidad pública en Aracaju - Sergipe, en el período de noviembre de 2015 a febrero de 2016, con 373 puérperas con edad gestacional ≥ 37 semanas, que permanecían al menos 30 minutos en preparto. Fueron utilizadas las pruebas ji-cuadrado y exacta de Fisher.
Resultados: las prácticas obstétricas de nivel "A" ofertadas fueron: baño tibio 109 (29,2%), masaje 62 (16,6%), bola suiza 50 (13,4%), deambulación 223 (59,8%), contacto piel a piel 250 (66,7%) y la presencia de acompañante 89 (23,9%). Fueron aplicadas prácticas nivel "B y D" como oxitocina 236 (63,3%), amniotomía 171 (45,8%), episiotomía 51 (19,8%) y Kristeller 129 (34,6%).
Conclusión: este estudio revela la necesidad de adecuación del entorno e implementación irrestricta de las buenas prácticas para garantizar atención segura al parto y nacimiento, y también contribuir a la formación de los nuevos profesionales.

DESCRIPTORES: Atención de salud; Parto humanizado; Práctica profesional; Enfermería materno-infantil; Enfermería obstétrica.

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INTRODUCTION

Birth is a moment when the woman experiences discomfort and pain while, socially, it represents the arrival of the new family member. Thus, the care team has been concerned with the humanization of birth care centered on the woman and the family. The protagonist role and biopsychosocial characteristics of the parturient woman should be respected[1].

The hospitalization of birth after the second world war turned it into a pathological condition centered on the physician and technologies, to the detriment of the woman's protagonist role[2]. To correct this trend, governmental actions have stimulated the humanization of birth care. At the end of the 1990's, the Ministry of Health launched the creation of the Normal Birth Centers (NBC) as a strategy[3]. Therefore, the guidelines of the World Health Organization (1996)[4] were taken into account, which classified the midwifery practices into recommendation levels "A, B, C, D". Level "A" corresponds to the practices of demonstrated utility that should be encouraged, such as calorie intake, walking and non-pharmacological pain relief methods, while level "D" corresponds to the practices frequently used inappropriately, such as fluid/food restriction and routine use of episiotomy. These practices were reaffirmed in 2018[5].

Simultaneously, the Ministry of Health funded training courses for nurse-midwives in almost all states of the federation, offered by the federal universities, besides sending these universities' faculty members for training in Japanese birth houses. On this occasion, in 1998, the first CPN was created in São Paulo, called "Casa de Parto de Sapopemba"[6].

In 2011, to enhance this change, the Stork Network was established and, once again, investments were made in the training of nurse-midwives. As from 2012, the Ministry of Health, in cooperation with the Ministry of Education, implemented qualification courses, 300 places in a specialization program and 134 places in Nurse Midwifery Residency (NWR), covering 15 Brazilian states.

On that occasion, the Federal University of Sergipe created the first class of residents in 2013, offering four places. This number increased to four in 2014. In the same year, the Specialization Course in Nurse Midwifery Stork Network started, coordinated by the Federal University of Minas Gerais, offering 15 places.

The NWR took place at the maternity hospital studied and gave rise to the interest in the theme. This research presents data that favor strategic planning for the implementation of the new care model, centered on humanized practices. Hence, the aim was to identify the midwifery practices adopted during delivery, labor and birth care at a public maternity hospital.

METHOD

Cross-sectional, analytic, quantitative study, developed between November 2015 and February 2016 at a maternity hospital located in the city of Aracaju, Sergipe.

This high-complexity service attends exclusively to the Unified Health System (SUS) and functions 24 hours per day on an open-door system. The midwifery center, where this study was carried out, is divided between the prepartum group room, delivery and c-section rooms and a post-anesthetic recovery room (PARR).

The population consisted of women attended at this maternity hospital. The estimated sample size was 373 postpartum women, considering that about 5,700 deliveries take place each year and accepting a 5% sampling error[7]. Postpartum women of any age were included, whose stayed at least 30 minutes in the prepartum room; with a gestational age of 37 weeks or more; in the first 48h postpartum, independently of the birth route. The exclusion criteria were: women admitted in the expulsion period and elective c-section.

The data were collected by means of documentary analysis and an interview with the postpartum women at the rooming-in unit during the first 48 hours postpartum. For the interview, a form was used with closed questions, completed by the researchers, addressing the sociodemographic and gynecological-obstetric variables of the sample, besides the delivery care practices offered at the maternity hospital. For the documentary analysis, the mother and infant's history and the pregnant woman's records were analyzed. To determine the social class, the classification of the Brazilian National Household Survey – PNAD was used[8].

The exploratory analysis of the data was performed using simple statistics. The variables were expressed as central trend measures, absolute and relative frequencies. Epi InfoTM 7 software was used for inferential analysis. Tests such as Pearson's Chi-squared and Fisher's Exact test were used to check for associations between the categorical variables, admitting a 5% statistical significance ($p < 0.05$).

The research complied with the Recommendations of National Health Council Resolution 466/2012 and approval was obtained from the UFS Research Ethics Commission under opinion 1.288.982. All participants and/or responsible caregivers signed the Free and Informed Consent Form.

RESULTS

The mean age of the interviewed women was 26 years, 86 (23.1%) of whom were adolescents and 236 (63.3%) between 20 and 35 years of age. 229 (61.4%) self-declared brown; 319 (85.5%) had a fixed partner; 210 (56.3%) had a low educational level; 240 (64.3%) were extremely poor, poor or vulnerable; did not exercise paid employment, 249 (66.8%) did not have a paid job and, of these, 215 (86.3%) did not receive government aid either. And 236 (63.3%) came from other cities in Sergipe.

Regarding prenatal care, 369 (98.9%) of the postpartum women reported having received antenatal care, 321 (86.1%) of them in public hospitals, 237 (64.5%) of them started early and 270 (73.2%) took part in at least six consultations. Only 87 (27.8%) participated in a group for pregnant women, 85 (27.8%) could visit the maternity hospital of reference, 214 (57.3%) reported peregrination, 117 (54.7%) of whom used their own transportation and 25 (11.7%) reported having peregrinated over two or more maternity hospitals (Table 1).

Table 1 – Distribution of postpartum women according to age range and data of last pregnancy. Aracaju, SE, Brazil, 2016 (continues)

Variable	<17		17-19		20-35		>35		Total	
	N	%	N	%	N	%	N	%	N	%
Antenatal care funding										
Sus	28	93.3	49	87.5	202	85.6	42	82.4	321	86.1
Private	-	-	1	1.8	6	2.5	1	2	8	2.1
Sus + private	2	6.7	5	8.9	27	11.4	6	11.8	40	10.7
Did not take part	-	-	1	1.8	1	0.4	2	3.9	4	1.1
Gestational age at start of antenatal care N= 369										
1st term	21	70	29	52.7	152	64.7	35	71.4	237	64.2
2nd term	7	23.3	21	38.2	72	30.6	12	24.5	112	30.4

3rd term	1	3.3	5	9.1	11	4.7	2	4.1	19	5.1
No records	1	3.3	-	-	-	-	-	-	1	0.3
Number of antenatal appointments N= 369										
< 6	8	26.7	21	38.2	62	26.4	8	16.3	99	26.8
≥ 6	22	73.3	34	61.8	173	73.6	41	83.7	270	73.2
Participated in group for pregnant women N= 369										
Yes	5	16.7	10	18.2	61	26	11	22.4	87	23.6
No	25	83.3	45	81.8	174	74	38	77.6	282	76.4
Visit to maternity hospital N=369										
Yes	9	30	15	27.3	50	21.3	11	22.4	85	23
No	21	70	40	72.7	185	78.7	38	77.6	284	77
Peregrination between institutions										
Yes	16	53.3	36	64.3	141	59.7	21	41.2	214	57.4
No	14	46.7	20	35.7	95	40.3	30	58.8	159	42.6
Type of transportation used by patients who peregrinated between institutions										
Private	10	62.5	19	52.8	80	56.7	8	38.1	117	54.7
Institutional	6	37.5	17	47.2	61	43.3	13	61.9	97	45.3

SOURCE: Data from research forms.

Of the 373 postpartum women, 115 (30.8%) underwent cesarean surgery. Among the 258 (69.2%) who gave birth through the vaginal route, 45 (17.4%) were assisted by nurse-midwives/nurse-midwifery residents and 213 (82.6%) by obstetricians/gynecology and obstetrics residents.

Of the physicians, 207 (63.1%) did not identify themselves at the time of delivery. On the other hand, 32 (71.1%) nurses presented themselves to the parturient women (p <0.0001). Regarding the calorie intake offered, 45 (12.1%) reported that oral liquid or solid foods were offered (Table 2).

Table 2 – Distribution of postpartum women according to the attending professional and the application of midwifery practices. Aracaju, SE, Brazil, 2016 (continues)

Variable	Attending professional				Total		
	Nurse		Physician				
	N	%	N	%	N	%	p
Did the professional present him/herself?							<0.0001
Yes	32	71.1	121	36.9	153	41	
No	13	28.9	207	63.1	220	59	
Were you allowed to drink or eat during labor?							0.3
Yes	8	17.8	37	11.3	45	12.1	
No	37	82.2	291	88.7	328	87.9	

Was your privacy guaranteed during labor or birth?							0.4
Yes	40	88.9	271	82.6	311	83.4	
No	5	11.1	57	17.4	62	16.6	
Was the partogram completed during labor care?							0.5
Fully	3	6.7	36	11	39	10.5	
Partially	23	51.1	49	14.9	72	19.3	
No	19	42.2	243	74.1	262	70.2	
Did immediate skin-to-skin contact take place?							0.0004
Yes	41	91.1	208	63.4	249	66.8	
No	4	8.9	120	36.6	124	33.2	
Was umbilical cord clamping done							
Timely	37	82.2	28	8.5	65	17.4	
Immediate	2	4.4	7	2.1	9	2.4	
No record	6	13.3	293	89.3	299	80.2	
Was amniotomy performed?							0.2
Yes	25	55.6	146	44.5	171	45.8	
No	20	44.4	182	55.5	202	54.2	
Was oxytocine applied during the dilation period?							0.2
Yes	33	73.3	203	61.9	236	63.3	
No	12	26.7	125	38.1	137	36.7	
Did the patient use a peripheral venous access during labor?							0.8
Yes	42	93.3	306	93.3	348	93.3	
No	3	6.7	22	6.7	25	6.7	
Was episiotomy performed (For patients who gave birth through the vaginal route only)							0.5
Yes	11	24.4	40	18.8	51	19.8	
No	34	75.6	154	72.3	188	72.9	
No register	-	-	19	8.9	19	7.4	
In case of episitiomy, was information provided on the execution of the procedure? N=51							0.9
Yes	6	54.5	25	62.5	31	60.8	
No	5	45.5	15	37.5	20	39.2	
Was Kristeller's maneuver performed?							0.5
Yes	13	28.9	116	35.4	129	34.6	
No	32	71.1	212	64.6	244	65.4	

SOURCE: Data from research forms

311 postpartum women (83.4%) stated that privacy was guaranteed in the obstetric center. Concerning the completion of the partograph, it was observed that this instrument was not used routinely, and that it was completed by three (6.7%) nurses and 36 (11%) physicians.

The association between timely clamping of the umbilical cord with the professional category that performed the delivery could not be evaluated as this information was not included in the medical record.

Amniotomy was performed in 171 (45.8%) women, 236 (63.3%) used synthetic oxytocin and an even larger number of women, 348 (93.3%), received a peripheral venous access.There was no association between the occurrence of episiotomy and the professional who provided care (p = 0.5). The 51 women who underwent episiotomy reported that the professionals did not inform that they would perform the procedure. The Kristeller maneuver was performed in 129 (34.6%) postpartum women.

For 284 (76.1%) women, no accompanying person was allowed at any time during labor and delivery (Table 3). Regarding non-pharmacological methods for pain relief, the nurse-midwives applied technologies during the delivery such as a warm bath 36 (80%), massage 28 (62.2%), the Swiss ball 23 (51.1%) and walking 42 (93.3%) (p <0.0001).

Table 3 – Distribution of postpartum women by attending professional and use of non-pharmacological pain relief methods. Aracaju, SE, Brazil, 2016 (continues)

Variable	Attending professional				Total		
	Nurse		Physician				
	N	%	N	%	N	%	P
Was a companion present at any time during labor or birth?							0.09
Yes	6	13.3	83	25.3	89	23.9	
No	39	86.7	245	74.7	284	76.1	
No companion N=284							
By choice	11	28.2	47	19.2	58	20.4	
Did not know	7	17.9	28	11.4	35	12.3	
Not allowed	21	53.8	170	69.4	191	67.3	
Was a lukewarm bath offered during labor?							<0.0001
Yes	36	80	73	22.3	109	29.2	
No	9	20	255	77.7	264	70.8	
Was a massage offered during labor?							<0.0001
Yes	28	62.2	34	10.4	62	16.6	
No	17	37.8	294	89.6	311	83.4	
Was the use of the Swiss ball offered during labor?							<0.0001
Yes	23	51.1	28	8.5	50	13.4	
No	22	48.9	300	91.5	323	86.6	
Was music turned on during labor or birth?							0.8
Yes	-	0	5	1.5	5	1.3	
No	45	100	323	98.5	368	98.7	
Were you allowed to move freely during labor?							<0.0001
Yes	42	93.3	181	55.2	223	59.8	
No	3	6.7	147	44.8	150	40.2	

Birth position (only vaginal birth) N=258							0.9
Lithotomy	44	97.8	211	99.1	255	98.8	
No lithotomy	1	2.2	2	0.9	3	1.2	

SOURCE: Data from research forms

What the type of delivery and care for the infant are concerned (Table 4), skin-to-skin contact occurred in 217 (83.8%) vaginal births (p=0.0001). In the vaginal births as well as in the c-sections, 354 (94.4%) infants were born with an Apgar score superior to seven and, to 314 (83.7%), the breast was offered in the first hour of life.

Table 4 – Distribution of infants according to type of birth and care for the unborn child. Aracaju, SE, Brazil, 2016

Variable	**Vaginal Birth**		**Caesarean Section**		**Total**		
	N	**%**	**N**	**%**	**N**	**%**	**p**
Skin to skin contact							<0.0001
Yes	217	83.8	33	28.4	250	66.7	
No	42	16.2	83	71.6	125	33.3	
Offering of maternal breast							0.03
Yes	224	86.5	90	77.6	314	83.7	
No	35	13.5	26	22.4	61	16.3	
1st minute Apgar							0.007
0 -4	1	0.4	4	3.4	5	1.3	
5-6	8	3.1	8	6.9	16	4.3	
7-10	250	96.5	104	89.7	354	94.4	

SOURCE: Data from research forms

DISCUSSION

The paradigm of childbirth care has changed and the protagonist role of the women in the pregnancy-postpartum cycle is currently considered one of the fundamental axes of humanization. This movement has not occurred homogeneously in the various services around the country though, with a care deficit from prenatal care until delivery[3].

As a characterization of the sample, there was a prevalence of non-white women with low income and education, which is related to less timely access to health services and higher risk of maternal mortality[9]. Another worrying factor was the high prevalence of adolescent pregnancy, revealing that there are flaws in the reproductive planning, given the non-planning of these pregnancies.

In order to guarantee humanized care, the guidelines for the midwifery practices that should be stimulated, such as calorie intake, proper ambience, monitoring of fetal well-

being, walking and non-pharmacological methods of pain relief, were reaffirmed in 2018[5].

When evaluating the occurrence of the best practices, it was observed that, although recommended, the calorie intake was infrequent, in view of the professionals' resistance against the prescription of the diet, alleging high risk environment and the need for possible anesthesia during delivery. There is insufficient evidence to recommend fasting in pregnant women with or without obstetric risk though[10].

Another recommended practice is the completion of the partograph, but this was neglected in the studied sample, corroborating several studies throughout Brazil[11-12]. The completion of the partograph is an indicator of quality of care, allows the caregiver to remain with the parturient in the delivery process and permits decision making at appropriate times[13].

In this research, it was evidenced that the professionals did not present themselves properly to the patients, failing to inform their name and professional category. Among those who presented themselves, there was a higher proportion of nurses, although it is worth mentioning the fact that, even among them, about 30% failed to present themselves. It is stressed that the humanization policy advocates that every person has the right to know the name and function of the assisting professionals[4].

The postpartum women stated that their privacy was guaranteed. This may be justified because they are unaware of the real meaning of privacy, leading them to believe that they were granted this right. Privacy cannot be observed in the maternity ward though, as the prepartum period takes place in a group room, without curtain walls between the beds, usually overcrowded and with patients in the corridors. These characteristics make the preservation of the female body unfeasible, generating more tension in the parturition process[14].

Despite the precarious structure, in addition to overcrowding, the nurses offered non-pharmacological pain relief technologies as recommended in the literature[5]. A study showed that, in deliveries attended by nurse-midwives, fewer unnecessary interventions occur, as they use non-invasive technologies with good practices related to humanization[15]. Walking was also stimulated. Scientific evidence shows that there is no justification for having women remaining in the supine position and emphasize the stimulation of movement and the vertical position[16].

The lithotomy position was adopted for most vaginal deliveries though. The absence of proper equipment was a difficult factor to guarantee the freedom to choose the delivery position. In contrast, a study carried out in Pernambuco showed that 78.9% of deliveries were attended in a non-lithotomic position. This was further facilitated because the maternity possessed resources such as a bench, horse, birthing bed and chair, which favor the woman's choice of the position she wishes to give birth in[1].

Another important fact is that skin-to-skin contact predominantly took place during births assisted by nurses. When the vitality of the infant is guaranteed, it is essential that skin-to-skin contact occurs to strengthen the affective bond. Because it is a moment when the mother and child are getting to know each other, the team needs to stimulate and allow this bond to happen, contributing to the transition to parenting[17].

Breastfeeding in the first hour after delivery occurred in most cases. The maternity is pursuing certification by the Baby-Friendly Hospital Initiative (BFHI). This initiative advocates breastfeeding still in the first hour of life, and was created to reduce maternal and neonatal morbidity and mortality and increase breastfeeding rates[18].

Although the frequency of episiotomy found was in accordance with the guidelines for normal humanized delivery[4], being below the national average[19], the professionals did not request the patient's authorization to perform it. In addition, there was no association between episiotomy and the professional category that attended the delivery. This finding differs from the study carried out in Recife, which found a lower prevalence of episiotomy

when the delivery was attended by nurses[20]. It is worrying that the professionals do not request the parturient woman's authorization, which infringes on the woman's autonomy and disrespects her protagonist role. It is emphasized that presenting oneself and asking for consent for the implementation of procedures are part of best practices[15].

In addition, non-recommended practices and situations that increase risk are still present in the care for these clients, such as the peregrination for access to the maternity hospital, despite having received prenatal care in the primary health care network, which demonstrates the noncompliance with the recommendation to bond the pregnant woman to her reference institution[3]. Some authors believe that the peregrination may be related to the deficit of obstetric beds in the Brazilian states[21]. In Sergipe, maternities in the interior of the state do not meet the existing demand, overloading the maternity wards of the capital.

Other practices such as amniotomy, the use of oxytocin and the use of peripheral venous access should be eliminated in childbirth care. They were frequently used though, with rates higher than those accepted in the literature[22]. These practices are remnants of obstetric training in the 1980s, when amniotomy and oxytocin were recommended for all parturients[23]. It should be noted that the indiscriminate use of oxytocin associated with amniotomy predisposes to acute fetal distress and increased rates of cesarean surgeries. Nevertheless, it is present at 70% of the Brazilian maternity hospitals[24].

Although it was banned in obstetrics and humanized birth care could not be stimulated, the Kristeller maneuver was performed in the sample studied, characterizing a practice of violence against women[25].

The participants did not have the right to freely choose their companion. This data reflects a violation of women's rights, characterizes institutional violence and causes frustration, as many women plan to involve a person to support them during labor and delivery[26].

Not allowing the entry of the preferred companion is justified by the overcrowding and constant lack of private clothing. In addition, the collective prepartum room, located inside the surgical center, prohibits the male companion. Although the companion law has existed since 2005, a survey conducted at maternity wards in Santa Catarina in 2011 showed that the entry of the companion was not allowed due to the lack of proper ambience[27-28].

Although in an unfavorable environment, such as situations of overcrowding, the professionals need to be sensitized, adopt the holistic model, with appropriate use of the midwifery practices, allowing the woman to act as protagonist and understand the delivery as a human experience and not as a purely biological event[21,24]. WHO[4] includes the involvement of women in decision making to ensure humanized obstetric care.

The main limitation in this study is that it was performed when the postpartum women were still in hospital, which often leads them not to complain out of fear of interferences in the treatment. Based on the results presented, we hope to contribute to the improvement of the obstetric quality of SUS users.

CONCLUSION

In view of the above, it is concluded that, despite the dedication and commitment of the professionals, the maternity under study partially accomplishes the best midwifery practices, with care being focused on interventions, especially due to the lack of physical resources such as appropriate ambience and equipment, as well as insufficient staffing, such as nurse-midwives.

Our findings corroborate those found in other regions of Brazil and reaffirm the need for greater commitment of public managers to the construction of CPNs in order

to guarantee the appropriateness of obstetric beds and proper staffing to promote good practices and safety during delivery and birth care.

This study reveals the need to adapt the ambience and implement the best practices without restrictions to ensure safe care during delivery and birth and contribute to the proper training of new professionals.

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