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Good practices in childbirth care and birth in a public maternity hospital

Boas práticas na assistência ao parto e nascimento em maternidade pública

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A B S T R A C T

This study aimed to describe the panorama of good practices in childbirth care and birth in a public maternity hospital. This is a report of the experience of the interprofessional team composed of professionals from nursing, social work, psychology, physiotherapy, medicine, pharmacy and nutrition, with a qualitative approach and critical-reflective and descriptive characteristics, in maternal and child care, at Hospital do Seridó, located in Caicó, Rio Grande do Norte. The research took place with the implementation written in a worksheet of good practices in childbirth and birth care, the data obtained refer to the period from July 2021 to March 2022, with data from 114 deliveries being collected in this period of time, in view of the indicators we have the following indicators: Freedom of movement (99%), presence of a companion (98%), free diet during labor (92%), deliveries without episiotomy (85%), breastfeeding in the first hour of life (85%), skin-to-skin contact (82%) and timely cord clamping (66%). In view of the analyzed data, it is concluded the importance of good labor and birth care practices provided as a hospital routine in the respective maternity hospital, thus being directly associated with the quality of health care provided by all professionals involved.

R E S U M O

Este trabalho objetivou descrever o panorama das boas práticas na assistência ao parto e nascimento de uma maternidade pública. Trata-se de um relato de vivência da equipe interprofissional composta por profissionais da enfermagem, serviço social, psicologia, fisioterapia, medicina, farmácia e nutrição, com abordagem qualitativa e características crítico-reflexivas e descritivas, na assistência materno-infantil, no Hospital do Seridó, localizado em Caicó, Rio Grande do Norte. A pesquisa se deu com a implementação escrita em planilha das boas práticas de assistência ao parto e nascimento, os dados obtidos são referentes ao período de julho de 2021 à março de 2022, sendo coletados dados de 114 partos nesse período de tempo, diante dos indicadores tem-se os seguintes indicadores: Liberdade de movimentação (99%), presença de acompanhante (98%), dieta livre durante o trabalho de parto (92%), partos sem episiotomia (85%), amamentação na primeira hora de vida (85%), contato pele a pele (82%) e clampeamento oportuno do cordão (66%). Diante dos dados analisados, conclui-se a importância das boas práticas de assistência ao parto e ao nascimento prestados como rotina hospitalar da respectiva maternidade, sendo assim associado diretamente a qualidade da assistência em saúde prestada por todos os profissionais envolvidos.

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Introduction

With the end of the Second World War, high rates of maternal and neonatal mortality were observed. As a result, and linked to the advancement and development of new knowledge and technologies in Medicine, childbirth crossed a process of institutionalization (Matos et al., 2013).

This process reformulated maternal and child health care, bringing benefits to it. Among benefits, it would be the improvement in assistance, mainly with regard to the actions to be carried out in case of complications that occurred during labor and at the time of birth, since this process could make use of technologies. (Leal et al., 2014).

Despite benefits, there are some harms, that were incorporated into institutionalization. Among these, it would be: the increase in elective cesarean sections, the perception of childbirth as a pathological process, the increase in unnecessary interventions even in normal births, the decrease in women's autonomy and the transfer of the woman's protagonist role to professionals responsible for car with childbirth (Cassiano et al., 2016).

As a result, society began to create a stereotypical image of the birth process. The natural perception of childbirth has become an event often filled with pain and suffering, which it is necessary to search for interventions, that culminate in the relief of this process, and contributes to the consolidation of the biomedical model (Cavaler et al ., 2018).

Studies indicate that interventionist practices are considered routine by health professionals. Excessive vaginal examinations, premature hospitalizations, indiscriminate use of intravenous oxytocin, episiotomies, elective cesarean sections, trichotomies, Kristeller maneuvers are common in many Brazilian maternity hospitals and can cause possible risks to the health of women and babies (Albuquerque et al. , 2019).

Based on this, the World Health Organization (WHO), aiming to humanize childbirth and change the current obstetric care model, begins to discuss the scientific evidence of these procedures and its benefits and harms to the health of women and newborns (Brasil, 2017). At the national level, government policies aimed at women's health were also improved and complemented, with the aim of implementing adequate, respectful and humanized assistance (Brasil, 2015).

Therefore, it is the responsibility of health services to adopt safe practices in labor and birth care. Furthermore, it is necessary that members of the women's care team seek to value and strengthen the dignity of women in labor, increasing their self-esteem and encouraging

their participation in planning their care, thus resulting in a reorganization of health assistance, through good practices (Brasil, 2011).

With this, and considering the incorporation of good labor and birth care practices and the consequent reduction of unnecessary interventions constituted in WHO recommendations and reinforced by the Ministry of Health, a set of actions were implemented that favored the implementation of good habits in labor and birth assistance at Seridó Hospital, that is the reference hospital for maternal and child health in the region.

Interprofessional assistance to pregnant women, parturients and newborns, focusing on the reorganization of work processes, the implementation of institutional documents that guide assistance, the use of non-pharmacological methods of pain relief and the reduction of unnecessary interventions, come being implemented, through a partnership between professionals from Seridó Hospital and the Multidisciplinary Residency in Maternal and Child Health at the Multicampi School of Medical Sciences, at the Federal University of Rio Grande do Norte.

Thus, this article aims to report the experience of an interdisciplinary team in assisting normal birth and birth in a public maternity hospital.

Theoretical Reference

Childbirth, in Ancient Age, was a family event, with the woman as the protagonist, and midwives providing assistance to the mother and child in a “non-hospital” environment. From the 19th century, it began to be treated as something that goes beyond the physiological, being associated with behaviors and the health professional become a new protagonist. Therefore, assistance to women during pregnancy and childbirth is still a challenge, mainly with regard to the act of caring and the implementation of good practices during labor and birth (Bonfim, 2018).

In Brazil, the hospital model in the birth scenario appears as an alternative to alleviate women's suffering, however, the results of this modification have negative repercussions, as they contributed to the existence of poor maternal and perinatal indicators caused, above all, by the use of inadequate technology, unnecessary interventions and deficient assistance that reflect the significant cesarean section rate (Soares et al., 2017).

Obstetric care followed a technocratic path, not based on scientific evidence, and consolidated itself in a hegemonic way within this model. It is considered that, due to progressive and increasingly invasive medicalization, the doctor's exercise of power over the woman's body has distanced her from her role as protagonist during childbirth, with a striking example being the change in the place of birth and the decline in women's autonomy throughout the labor process (Riegert et al., 2018).

In 2000, the Health Ministry created a new strategy: the PHPN with respect for sexual and reproductive rights and humanization in assistance as a backdrop. The PHPN is based on the right to humanization of obstetric and neonatal care as a primary condition for adequate monitoring, establishes criteria to qualify care and promote the link between outpatient care, in addition to pointing out actions to reduce maternal and neonatal mortality (Brasil, 2014).

Still in 2011, the federal government launched a new strategy with the prospect of leveraging the PHPN: Cegonha Net. This program is a set of actions that aim to guarantee quality care to all Brazilian women through the SUS, from confirmation of pregnancy to the first two years of the baby's life, with action integrated with other SUS initiatives for women's health (Brasil , 2011).

Cegonha Net is organized through four components: prenatal care; labor and birth; puerperium and comprehensive care for children's health and, finally, logistical system. Its guidelines ensure: assessment and classification of women's risk and vulnerability; expand access and improve the quality of prenatal care; linking the pregnant woman to the reference unit and safe transportation; good practices and safety in labor and birth care; health care for children aged zero to twenty-four months with quality and resolution and, finally, access to reproductive planning actions (Brasil, 2011).

In 2016, the Health Ministry, in an attempt to respond to the epidemic of cesarean sections, launched a Clinical Protocol of Therapeutic Guidelines for cesarean sections, with guidelines for this type of birth, aiming to reduce the number of unnecessary cesareans, since the procedure, when it is not indicated correctly, it poses more risks to the lives of the mother and baby, in addition to increasing the likelihood of the risk of maternal and child death (Brasil, 2016).

In 2022, the stork network was replaced by the Maternal and Child Care Network, restructured by ORDINANCE GM/MS N. 715, APRIL 4, 2022. The policy's objectives are to implement a safe, quality health care model and humanized, focusing on family planning, pregnancy, prenatal care, birth, pregnancy loss, the postpartum period and the care of newborns and children, promoting healthy growth and development; ensuring comprehensive care with a focus on resolving primary care and specialized outpatient and hospital care; and reduce maternal and child morbidity and mortality (Brasil, 2022).

Methodology

This experiment consists of a report on the experience of an interprofessional team (composed of professionals from nursing, social work, psychology, physiotherapy, medicine, pharmacy, nutrition and obstetricians) with a qualitative approach with critical-reflective and

descriptive characteristics, in maternal and child care, at Seridó Hospital, in Caicó/Rio Grande do Norte.

To begin the implementation of actions related to good practices, training was carried out with hospital residents and professionals on humanization, labor and birth, followed by the development and implementation of protocols and institutional documents to guide care. Some equipment was also purchased for support in the implementation of non-pharmacological methods such as blue light, aroma diffuser, massager, among other things.

Trainings were carried out using expository and dialogued classes and with active methodologies, when the themes were appropriate, they included active participation from the listeners and provided important moments of reflection to change the assistance. The institutional documents and protocols implemented began with forms of reception, admission and nursing evolution, followed by protocols on the most diverse themes and situations that permeate assistance to the mother-child binomial, such as: admission of pregnant women, assistance in different periods of labor, amniotic bag rupture, newborn care, newborn bathing, postpartum hemorrhage assistance and so on.

Finally, with regard to records, a spreadsheet was created in the delivery room that allows the survey of the implementation of good practices, recommended by the WHO and the Health Ministry. Thus, respecting all ethical issues to collect the exposed data, it was used This spreadsheet is fed by nurses who work in the delivery room every day.

Results and discussion

At Seridó Hospital, good labor and birth care practices began to be part of the routine of obstetric and newborn care, with worth highlighting by the data shown in table 1.

The data collected were analyzed using descriptive statistics and presented in table form. The data obtained refers to the period from July 2021 to March 2022. In the period outlined, data from 114 births attended at Seridó Hospital were collected.

Table 1 – Good practices in natural birth care

Skin-to-skin contact	n	%
Yes	94	82
No	20	18
Timely cord clamping		
Yes	75	66
No	39	44
Breastfeeding in the first hour of life		
Yes	97	85

No	17	15
Free diet during labor of childbirth		
Yes	105	92
No	9	8
Episiotomy		
Yes	17	15
No	97	85
Presence of companion-person		
Yes	112	98
No	2	2
Freedom for movement		
Yes	113	99
No	1	1

According to table 1, data related to the following indicators were observed regarding the newborn: skin-to-skin contact (82%), timely cord clamping (66%), and breastfeeding in the first hour of life (85%). Related to assistance to women in labor, the following are worth highlighting: free diet during labor (92%), births without episiotomy (85%), presence of a companion-person (98%) and freedom for movement (99%).

Care for newborns, immediately after birth and in the first hours of life, has a great importance for their survival and healthy development (Muller & Zampieri, 2014). For the Health Ministry (2007), there are three simple practices that can be carried out in healthy newborns shortly after birth that offer benefits for mother and baby: skin-to-skin contact between mother and newborn, breastfeeding and timely clamping of the umbilical cord.

Timely umbilical cord clamping refers to the practice of clamping the umbilical cord approximately 1 to 3 minutes after birth or after the umbilical cord pulse stops (Chaparro & Lutter, 2007). This practice has been recommended by the WHO since 2007, by the Health Ministry and by the Brazilian Society of Pediatrics in 2011, in which the newborn must be positioned on the mother's abdomen by approximately three minutes before clamping the umbilical cord (Farias & Morais, 2020).

Skin-to-skin contact calms the mother-baby binomial who enter into a unique harmony provided by this moment, also helping to stabilize the child's blood, heartbeat and breathing, reducing crying and stress in the newborn with less loss of energy and keeps the baby warm by transmitting heat from its mother.

Breastfeeding stands out as a benefit of immediate contact by making sucking efficient and effective, increasing the prevalence and duration of lactation, in addition to positively influencing the mother-child relationship (Matos et al., 2010).

The bond that breastfeeding promotes between mother and child becomes a reward for a unique and singular moment, which strengthens the bonds between them. Enabling a better understanding of the baby's needs, facilitating the mother's performance and facilitating the newborn's extrauterine adaptation (Silva, 2015).

Having proven the immunological, nutritional and psychosocial benefits of breastfeeding for both women and children, efforts have been made to promote, protect and support the practice of breastfeeding, highlighting the implementation of policies and actions to provide children with the best possible start in life. The Baby-Friendly Hospital Initiative is part of this context, launched in 1991 and adopted by more than 20,000 accredited hospitals in more than 156 countries in the last 15 years (Matos et al., 2013).

With regard to freedom of position and movement during labor, an experimental study showed that women able to move freely during labor reported movement as a means to find a comfortable position (Wei & Santos, 2011). Other research shows that women who were encouraged to stand, walk or sit had, on average, shorter labors than women who remained lying down (Leite, 2014).

However, a ritual was created in hospitals to monitor parturient women, using increasingly sophisticated devices, resulting in parturient women being restricted to bed, in order to monitor each variation in fetal heartbeats. As a consequence, the restriction on the movement of women in labor has become a practice embedded in the cultural universe of professionals, generating insecurities regarding the adequate progress of labor and fetal well-being, if this is not constantly monitored (Wei & Santos, 2011).

Another point to be explored is the restriction of food and liquids during labor in childbirth. For women who are in the early stages of labor and want to eat, mandatory fasting can cause an unsatisfactory progression, falling into the cascade of interventions that culminate in a cesarean section (Santos et al., 2019).

During the parturition process, energy expenditure is equivalent to continuous moderate physical exercise and, in the case of prolonged labor associated with fasting, there is a progressive increase in urinary ketones. This excessive concern, among professionals with dietary restrictions, is due to the risk of aspiration of gastric contents if the parturient woman regurgitates, during an anesthetic procedure; however, evidence indicates that the risk of aspiration is directly associated with the use of general anesthesia in birth, which is currently very low, in addition to the care of the professional who administers the anesthesia (Ascensão, 2016).

National and international guidelines on natural birth assistance recommend the presence of a companion during labor and birth, which is an action converging on the humanization of health care at this time. This perspective is expanded in discussions and priority in obstetric health care actions with a view to strengthening the human relationships involved in this process, which has focused on carrying out interventions and procedures. Therefore, enabling and guaranteeing the presence of a companion is considered a dignifying practice in caring for women during childbirth (Gomes, 2018).

The presence of a companion-person of the woman's free choice is recognized as one of the actions to be adhered to for good practices in natural birth care, guaranteed in Brazil by Law 11,108.6, which guarantees it as a right of the parturient woman. This is a strategy of the Health Ministry with the purpose of structuring and organizing maternal and child health care in the country, with a view to implementing a care network that encompasses the right to reproductive planning and humanized care during pregnancy, childbirth and the postpartum period (Esswein et al.,2021).

By the way, evidence indicates that women in labor choose to have a companion during labor and birth, most of the time being their partner or their mother (Sousa et al., 2016). Considering the experiences at this moment, the companion provides support in the emotional and physical spheres, making the woman feel safe, characterizing this as a recommended practice for all women in labor. This confirms that offering quality obstetric care also means reflecting on the family's involvement in different care contexts (Gomes, 2018).

The WHO and the Health Ministry recommend the restricted use of episiotomy and classify its routine and liberal use as a harmful practice, which should be discouraged, with an indication on average of 10% to 15% of cases. There is a statistically significant relationship between the use of episiotomy and the increased risk of severe lacerations (3rd and 4th degrees), with anal sphincter injury. Studies have shown that births carried out without episiotomy, there were no records of serious injuries (Salge et al., 2012).

Episiotomy is one of the most frequent causes of maternal morbidity during the postpartum period, as it exposes women to increased blood loss, infection, sexual dysfunction such as dyspareunia, urinary incontinence, vaginal prolapse, among other changes when compared to other types of perineal trauma. The Municipal Health Department of Rio de Janeiro has used the Obstetric nurse as an important strategic agent in the implementation of humanized obstetric practices. In this sense, nurse training focused on human care effectively contributes to the creation of humanized practices, based on respect and shared decisions (Araújo et al., 2021).

The study carried out in Minas Gerais also shows that most parturients gave birth in the lying position, it is not known whether by choice or imposition, which is in line with the

data collected in this research, with the majority of women reporting that they had not been given any option of giving birth in other position if not lying down. The author also reinforces that postpartum women also perceive adopting the vertical position for childbirth as beneficial, as it is more comfortable, favors movement and participation and reduces expulsive effort. Therefore, if guided and encouraged, pregnant women will probably accept the adoption of different positions during labor and birth (Sousa et al., 2016).

It is noteworthy that freedom of position still represents a challenge for obstetric nursing, whether on the part of some professionals involved in multidisciplinary care or due to the lack of guidance for women regarding this possibility during pregnancy, which causes strangeness at the time of birth.

When talking about episiotomy, it was performed in 14.6% of postpartum women, similar to the study in Rio Grande do Sul, where obstetric nursing is also very common (Reis et al., 2015).

A study, carried out in Curitiba/Paraná, in relation to perineal lacerations, shows that, in low-risk birth care, among 511 postpartum women interviewed there were no lacerations in 240 births (46.96%), 1st degree lacerations in 180 births (35.22%) and 2nd degree lacerations in 91 births (17.80%). There were no 3rd and 4th degree lacerations in this period studied (Sobieray & Souza, 2019).

Data such as this study reinforce the WHO recommendations to recommend restricting the routine use of episiotomy and establishes the rate between 10% and 30% as acceptable (OMS, 1996). For some authors, the routine practice of this procedure is classified as clearly harmful, should be discouraged and is not supported by current scientific evidence as it causes more harm than good (Santos et al., 2017).

Brazilian obstetric practice is permeated by the rush to bring about the birth of children, often disregarding women's autonomy in the parturition process. This is a striking characteristic in the conduct of the vast majority of professionals who believe they “conduct” labor. It is evident that interventionist practices that aim to accelerate labor, such as amniotomy or oxytocin infusion, are still strongly associated with birth care (de Matos, 2021).

With regard to encouragement for breastfeeding, postpartum women reported having received it (91.7%), as well as support from the team (93.8%) and contact with the baby while still in the delivery room (93.8%). Authors state that less interventionist care is closely associated with greater satisfaction with the birth experience and the performance of EO (REIS et al., 2015).

With good outcomes, this less interventionist care model reinforces what scientific evidence brings regarding maternal and perinatal morbidity and mortality, both in the public and private health systems (Reis et al., 2015). Statements like this suggest that reducing

maternal deaths is possible, however, it requires actions and strategies aimed at reducing maternal deaths, valuing childbirth and its assistance through EO.

Thus, the positive impact of EO's actions in the scenario of childbirth assistance and births with usual risk is reinforced. With a less interventionist practice, and focused on the implementation of good practices, valuing and empowering women's role as protagonists in the birth scenario (Marques & Siqueira, 2021).

Conclusion

Among the good practices analyzed in labor and birth care, it was seen that the majority had good adherence, with only timely cord clamping being the least performed, but still presenting a result equal to 66%. Therefore, there are reasons for not carrying out timely clamping.

The study proves the experience of hospital service professionals, presenting the reality of obstetric care, of a maternity hospital linked to the title of child-friendly hospital and which meets the main objectives and guidelines of the Maternal and Child Health Care Network. Therefore, it is notable through the results of the implementation and expansion of good practices in the maternity ward, contributing to an improvement in obstetric care in the municipality.

This study is expected also to raise awareness among health professionals regarding the quality practice of good labor and birth care practices, correct recording of data for real data collection in future publications.

Therefore, multidisciplinary assistance must focus its care on the humanization of labor and birth, guaranteeing the woman and her baby general well-being, that is, considering cultural, social and racial aspects. The entire team must pay attention to the importance of adhering to good labor and birth care practices to effectively contribute to the qualification of assistance and care.

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