Revista de Enfermagem e Atenção à Saúde
REAS

ORIGINAL ARTICLE
DOI: 10.18554/reas.v10i3.4567
e202131

NATURAL CHILDBIRTH CARE PROFILE AT A MATERNITY HOSPITAL OF A FEDERAL SCHOOL

PERFIL DA ASSISTÊNCIA AO PARTO NORMAL EM UMA MATERNIDADE ESCOLA FEDERAL

PERFIL DE LA ASISTENCIA AL PARTO NORMAL EN UNA MATERNIDAD ESCUELA FEDERAL

Francini de Souza Rodrigues[1], Cristiane Barbosa Batista[2], Geiza Martins Barros[3]

How to cite this article: Rodrigues FS, Batista CB, Barros GM. Natural childbirth care profile at a maternity hospital of a federal school. Rev Enferm Atenção Saúde [Internet]. 2021 [access:____]; 10(3):e202131. doi: https://doi.org/ 10.18554/reas.v10i3.4567

ABSTRACT

Objective: This study aimed to characterize the care to natural childbirth at the maternity hospital of a federal school located in the city of Rio de Janeiro. **Method**: This is a quantitative descriptive study. Data were collected from the records of local natural childbirths from July to December 2018. In total, 466 births were performed, 97 of which were excluded according to the inclusion criteria; then 369 records were analyzed. Data were analyzed using Microsoft Excel 2013 with the description of absolute and relative data. **Results:** Care to natural childbirth was provided with evidence-based practices, including the presence of a companion during labor and delivery in 90.79% of the cases, and encouraging breastfeeding in 78.32%. Practices that are not usually recommended were also observed, like amniotomy in 30.08% and episiotomy in 20.87%. **Conclusion**: Care in the studied maternity was predominantly based on good care practices.

Descriptors: Natural Childbirth; Humanizing Delivery; Midwifery

[1] RN. Perinatal Health Specialist by Maternidade Escola da UFRJ. Rio de Janeiro, Brazil. E-mail: francinidesouza.rodrigues@gmail.com
2 Master in Epidemiology in Public Health at ENSP/FIOCRUZ. Specialist in Family Health by Escola Nacional de Saúde Pública Sérgio Arouca – FIOCRUZ. RN by Universidade Federal do Estado do Rio de Janeiro. E-mail: cristiane.batist@gmail.com
3 Doctorate student in Health Sciences (IFF/Fiocruz). Master in Health Sciences (IFF/Fiocruz). Obstetric Nurse (UERJ). E-mail: geiza_mb@hotmail.com

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RESUMO

Objetivo: Caracterizar a assistência ao parto normal em uma Maternidade Escola Federal, no município do Rio de Janeiro. **Método**: Pesquisa descritiva, de abordagem quantitativa. Os dados foram coletados a partir dos registros de partos normais locais no período de julho a dezembro de 2018. No total foram realizados 466 partos, sendo 97 excluídos pelos critérios estabelecidos, dessa forma, foram analisados 369 registros. Para a análise dos dados foi utilizado o programa Microsoft Excel 2013 com a descrição dos dados absolutos e relativos. **Resultados**: a assistência ao parto normal contou com práticas baseadas em evidências científicas, como a garantia do acompanhante no trabalho de parto e parto, com 90,79% e estímulo ao aleitamento materno, em 78,32%, mas também, fez-se presente práticas desaconselhadas rotineiramente tais como: amniotomia, em 30,08% e episiotomia em 20,87%. **Conclusão**: observou-se que a assistência na referida maternidade se baseou, predominantemente, nas boas práticas assistenciais.

Descritores: Parto Normal; Parto Humanizado; Tocologia.

RESUMEN

Objetivo: Caracterizar la asistencia al parto normal en una Maternidad Escuela Federal, en la ciudad de Rio de Janeiro. **Método**: Investigación descriptiva, con enfoque cuantitativo. Se recolectaron datos de los registros de partos normales locales de julio a diciembre de 2018. En total se realizaron 466 partos, de los cuales 97 fueron excluidos por los criterios establecidos, por lo que se analizaron 369 registros. Para el análisis de los datos se utilizó Microsoft Excel 2013 con la descripción de datos absolutos y relativos. **Resultados**: En la asistencia al parto normal se realizaron prácticas basadas en evidencia científica, como garantizar un acompañante en el trabajo de parto y parto en el 90,79% de los casos y fomentar la lactancia materna en el 78,32%, pero también se realizaron prácticas que no se aconsejan habitualmente como: amniotomía en el 30,08% y episiotomía en el 20,87%. **Conclusión**: Se observó que la asistencia en la maternidad referida se basó predominantemente en buenas prácticas de cuidado.

Descriptores: Parto Normal; Parto Humanizado; Tocología.

INTRODUCTION

The childbirth process has changed over the years. In the past, births were mostly performed in the homes of future mothers; but later it became a hospital procedure using the most different health care technologies.[1] Considering these changes, in the second half of the 20th century, a global movement started to encourage a return to the origins of childbirth, with humanizing assistance to childbirth, which reinforced the special role of women during natural childbirth. This idea was materialized into documents and public policies that have enabled new practices of delivery assistance, based on scientific evidence.

On February 14, 2017, Ordinance 353 from the Ministry of Health was published, which provides guidelines based on scientific evidence for assistance to natural delivery for women with habitual risk pregnancy. These recommendations were the result of a detailed review of

scientific studies of different qualities, mainly considering more robust and reliable papers.[2]

The practices that should be encouraged include the use of a partogram, offering fluids orally or light diet during labor and delivery, non-invasive and non-pharmacological methods for pain relief, freedom of movement and position for women during labor. The use of analgesic drugs should be an option for women after attempts with non-pharmacological methods for pain relief. Skin-to-skin contact between mother and newborn and breastfeeding in the first hour of life are essential for the mother-baby bond and help reduce postpartum hemorrhage.[3]

On the other hand, practices that are clearly harmful or ineffective and must be eliminated include routine use of enema and trichotomy. Routine episiotomy and Kristeller maneuver are not recommended, and directed pulls must be avoided.[3]

Early amniotomy, early cord clamping, and administration of oxytocin after an analgesic drug should not be used routinely and should only be considered when necessary. Controlled cord traction in the third stage of labor can help reduce the risk of manual removal of the placenta and can be used in women who choose it.[3]

Among the most recent initiatives related to humanizing childbirth care in Brazil, the ‘Apice On’ project adopted in 97 school hospitals in the national territory proposes to “qualify professionals in the fields of childbirth and birth attention/care, postpartum and postabortion family planning, care for women in situations of sexual violence and abortion and legal abortion.”[4]

In 2018, the World Health Organization (WHO) published the “*Intrapartum care for a positive childbirth experience,”* an important document with 56 scientific recommendations for labor, delivery and postpartum period, and a list of newborn care aiming to promote a humanized experience of natural childbirth.[5]

In view of the official recommendations described as good care practices and considering the study unit (maternity hospital of a federal school) trains specialists in this field, this study aimed to characterize the assistance to natural childbirth in a maternity hospital of a federal school located in the municipality of Rio de Janeiro.

METHOD

This is a cross-sectional quantitative descriptive study. The study was conducted in a public maternity hospital of a federal school located in the municipality of Rio de Janeiro. It offers outpatient and inpatient multiprofessional

care, including specific care for pregnant women and high-risk infants. It has outpatient services specialized in prenatal care (arterial hypertension, diabetes, twin pregnancy, fetal pathologies, and adolescents), risk screening program for pregnant women in the first trimester, family planning for women at risk, prenatal genetic testing, and fetal medicine.

Data were collected from a book of natural childbirth records from the institution; data collection was conducted from June to August 2019 using an instrument developed by the authors, which contained closed-ended statements related to the practices adopted in the assistance to natural childbirth, filled with ‘yes’ or ‘no.’ Data collection took place.

The inclusion criteria of this study were records of women who had natural delivery performed at the obstetric center of the institution, and the exclusion criteria were records of women who had natural delivery but with a stage of expulsion, women with preterm delivery (childbirth before 37 weeks of pregnancy are completed), women without gestational age records, and deliveries performed outside the obstetric center. Twin births were considered as one delivery, applying the same exclusion and inclusion criteria. All records were analyzed from July to December 2018, with 466 deliveries. Of these, 97 deliveries were excluded according to the study criteria. Then, 369 deliveries were eligible for this study.

Ethical aspects for research involving human beings from Resolution 466/12 of the National Health Council were respected when conducting this study.[6] In order to emphasize the importance of confidentiality and ethical aspects in research, this study was submitted to the Research Ethics Committee and approved under nº 3.339.596.

Microsoft Excel 2013 was used for data analysis – first for data condensation after collection and later in descriptive statistics with description of absolute and relative frequencies, which were presented in tables.

Studied variables were grouped into the following categories: 1. Sociodemographic characteristics and obstetric history (race/color, age group, prenatal care, and number of deliveries); 2. Practices of assistance to natural childbirth based on scientific evidence (presence of a companion during labor and delivery, proper diet, use of non-pharmacological methods for pain relief, analgesic drug, optimal timing for cord clamping, skin-to-skin contact skin, and breastfeeding within the first hour of life); and 3. Practices of assistance to natural childbirth that are not routinely recommended (artificial oxytocin during labor, amniotomy, episiotomy, and

lithotomy position), and prohibited practice (Kristeller maneuver).

RESULTS

Table 1 shows sociodemographic characteristics and obstetric history of records, indicating the most predominant self-declared race/color was brown, followed by white and black. Regarding the age group, the predominant group was 20 to 35 years.

Regarding prenatal care, almost all women performed it. As for parity, just under half of the women were nulliparous.

Table 1 – Distribution of variables for sociodemographic characteristics and obstetric history – July to December 2018.

Race/Color		
	N	**%**
White	98	26.56
Black	63	17.07
Brown	181	49.05
Yellow	1	0.27
Race/Color (continuation)		
Indigenous	1	0.27
Not informed	25	6.78
Age group		
	N	**%**
15 to <20 years	39	10.57
20 to 35 years	264	71.54
Over 35 years	51	13.82
Not informed	15	4.07
Prenatal care		
	N	**%**
Yes	363	98.37
No	2	0.54
Not informed	4	1.09
Parity		
	N	**%**
Nulliparous	172	46.61

1 delivery	124	33.60
≥ 2 deliveries	72	19.51
Not informed	1	0.27

Source: Book of natural childbirth records, 2019.

Table 2 shows some of the practices based on scientific evidence recommended for natural childbirth. Based on this information, most women had a companion during labor and delivery, and proper diet was provided during this period. In addition, just over half of the women used showering as a non-pharmacological method for pain relief. In just over half of the births, analgesic drugs were not required.

Regarding newborn practices, more than half of the births had optimal timing for cord clamping, and immediate skin-to-skin contact and breastfeeding.

Table 2 – Distribution of variables of care practices for natural childbirth based on scientific evidence – July to December 2018.

Companion		
	N	**%**
Yes	335	90.79
No	34	9.21
Diet		
	N	**%**
Zero	29	7.86
Yes	332	89.97
Not informed	8	2.17
Non-pharmacological methods for pain relief*		
	N	**%**
Showering	242	65.58
Respiratory exercises	176	47.70
Massage	140	37.94
Deambulation	173	46.88
Facilitating movements	131	35.50
Ball	113	30.62
Music	60	16.26
Other	23	6.30
Did not accept	11	2.98
Not informed / Not performed	72	19.51
Analgesic drug		
	N	**%**

Yes	147	39.84
No	221	59.89

Analgesic drug (continuation)		
Not informed	1	0.27
Optimal timing for cord clamping		
	N	**%**
Yes	296	80.22
No	68	18.43
Not informed	5	1.35
Skin-to-skin contact		
	N	**%**
Immediate	312	84.55
First 30 minutes	24	6.50
First hour	2	0.54
None	29	7.87
Not informed	2	0.54
Breastfeeding		
	N	**%**
Yes	289	78.32
No	72	19.51
Not informed	8	2.17

*The sum is not 100% due to use of more than one method.

Source: Book of natural childbirth records, 2019.

Table 3 shows the number of women submitted to natural childbirth practices that are not routinely recommended or prohibited according to current scientific evidence. Regarding the natural childbirth practices that are not routinely recommended, just over half of the births used artificial oxytocin, and amniotomy and episiotomy were used less significantly, but a very significant number of pregnant women used the lithotomy position. For prohibited practices, Kristeller maneuver was used.

Table 3 – Distribution of variables of care practices for natural childbirth not routinely recommended or prohibited – July to December 2018.

Oxytocin during labor		
	N	**%**
Yes	202	54.74
No	167	45.26
Amniotomy		
	N	**%**
Yes	111	30.08
No	251	68.02
Not informed	7	1.90
Episiotomy		
	N	**%**
Yes	77	20.87
No	291	78.86
Not informed	1	0.27
Birth position		
	N	**%**
Lithotomy	321	86.99
Not informed	48	13.01
Kristeller maneuver		
	N	**%**
Yes	11	2.98
No	356	96.48
Not informed	2	0.54

Source: Book of natural childbirth records, 2019.

DISCUSSION

The sociodemographic profile of the study population showed that 49.05% had brown skin. A study that evaluated the obstetric and neonatal profile of puerperal women treated at two public maternity hospitals in São Paulo showed a similar percentage: 55.2% of the puerperal women were brown.[7]

The study showed 71.54% of pregnant women were 20 to 35 years old. These data are similar to those of a study that evaluated the model adopted by a respectful maternity hospital in São Paulo,

which found 69.8%.[8] Such data may indicate the studied population is aging, that is, fewer women have become mothers at a younger age.

Regarding prenatal care, 98.37% of women performed it during the current pregnancy in this study. This result agrees with that of another study, which presented practically the same percentage, with 98.3% among the puerperal women.[7] This situation indicates better accessibility to prenatal care.

The study findings for parity indicate 46.61% for nulliparous women, 33.60% for women with a previous delivery, and 19.51% for two or more previous deliveries. Of note, these data are different from those found in another study that evaluated delivery and birth care at a university hospital in the city of Porto Alegre, Rio Grande do Sul, comparing the practices developed after the implementation of the 'Stork Network' program between 2012 and 2016, and which obtained 59% for nulliparous women, 24.8% for women with a previous delivery and 16.2% for two or more previous deliveries in 2016.[9]

Regarding the presence of a companion during labor, this practice was performed in 90.79% of the births, slightly below the rate of 96.9% reported in 2016 by another study.[9] Federal Law 11.108 of April 7, 2005 "ensures parturient women the right to the presence of a companion during labor, delivery and immediate postpartum period, within the scope of the Brazilian National Health System (SUS)."[10] Then, in the studied institution, this law is enforced, allowing a male or female companion during labor, selected by the pregnant woman.

Offering a liquid diet and food during labor is recommended by the WHO.[5] This study found 89.97% of women received a diet during labor, higher than the rate reported in a study named "Nascer no Brasil" conducted from 2011 to 2012, which evaluated obstetric care in 266 hospitals of 191 municipalities; however, the article in question analyzed the habitual obstetric risk and presented 25.2% of all women receiving a diet during labor.[11]

The use of non-pharmacological methods for pain relief should be offered to women in labor, as recommended by the Ministry of Health in its guidelines for assistance to natural childbirth.[3] Of note, in the studied maternity hospital, non-pharmacological methods are offered and represent the basic nursing care in the obstetric center, which also has standard instruments for registration. Then, in this study, 65.58% of women used showering, followed by breathing exercises, deambulation and massage, with rates of 47.70%, 46.88% and 37.94%, respectively. A study conducted about assistance to

natural childbirth performed by obstetric nursing residents in a large municipal public maternity hospital in Rio de Janeiro found the following rates: 87.1% for breathing techniques, 50.7% for deambulation, 44.9% for warm showering, and 33.8% for massage.[12] Such data indicate that every woman has her own particularities and preferences when choosing a non-pharmacological method.

Pharmacological methods for pain relief should be offered after trying to use non-pharmacological methods for pain relief.[3] Therefore, the study showed 39.84% of women opted for an analgesic drug, which is lower than the rate of 45.9% reported in 2016.[9] A relevant aspect is the performance of the nursing team, as these professionals must inform the woman in labor what can happen with the use of analgesic drugs, so that she is able to make a well-informed decision.[13]

Optimal timing for cord clamping should be one to five minutes after birth, or when there is no longer a pulse; it is newborn care that should be performed in all births, except for those cases with contraindications related to the umbilical cord or when neonatal resuscitation is required.[3] Such practice "increases the level of hemoglobin and improves iron stores in the first months of life."[14] Then, this study showed a high rate of this practice: 80.22%; the studied institution considers optimal timing for cord clamping when it is performed between one and three minutes after birth.

Skin-to-skin contact between mother and baby should happen soon after birth, in the first hour of life, with benefits to all newborns as long as they are healthy. It helps prevent neonatal hypothermia and encourages breastfeeding.[5] In addition, it effectively colonizes the newborn with the mother's microbiota.[15] Then, this study presented 84.55% of births with immediate skin-to-skin contact. This rate is higher than that reported in a study mentioned above, which was 60.1% in 2016.[9] However, despite this contact between the mother and baby after birth, in the studied institution, this practice is not rigorously respected, as both are separated in this first hour to perform routine procedures, such as, anthropometric measurements and vaccination.

Breastfeeding should start immediately after birth, as long as mother and newborn are able to do so;[5] studies show that early breastfeeding produces better results for the child health.[16] So, this study showed a high rate of breastfeeding after delivery: 78.32%, much higher than the rate of 45% reported in 2016.[9]

Using oxytocin to induce labor is a practice not recommended by the WHO.[5] It should be used only after confirmation of interrupted progression in the first stage of

labor or when the mother has ineffective uterine contractions in the second stage of labor.[3] Then, the findings of this study showed oxytocin administration to 54.74% of all deliveries, a lower rate than that reported in a previous study, which presented 81.9% oxytocin use in 2016.[9] However, other studies found even lower rates of oxytocin use of 36.4% for all women [11] and 28.6%.[8] Of note, the studied records had no indication of oxytocin in labor, only remarks of whether it was used or not.

Early amniotomy to prevent delay in labor is not recommended by the WHO.[5] It should be used only after confirmation of interrupted progression in the first stage of labor or with suspected extended labor in its second stage.[3] Our study found amniotomy was performed in 30.08% of deliveries. This result differs from the others that presented rates of 21.5%[8] and 39.1% for all women.[11] Once again, the studied records had no indication of amniotomy in labor, only remarks of whether it was used or not.

Routine episiotomy is not a practice for "spontaneous vaginal delivery."[5,3] However, its application must be selective[17] and have a justification.[3] Then, this practice was performed in 20.87% of all cases. However, this rate was lower than those found in the literature, such as 55% in 2016[9] and 53.5% for all women.[11]

Although the literature highlights episiotomy should not be a routine procedure, but a selective practice, data presented above show its performance is still common in hospitals. Therefore, the professional assisting the childbirth should assess the real need to perform it.

Regarding the birth position, it is recommended "to discourage the supine position, horizontal supine position, or semi-supine position in the second stage of labor. Women should be encouraged to adopt any other position they find more comfortable, including squatting, side lying or all-fours."[3] In this study, 86.99% of women delivered in the lithotomy position, also known as supine, a high percentage, similar to those that showed 98.7% in 2016[9] and 91.7% for all women.[11] Therefore, the adoption of other types of positions should be further encouraged, but the woman's choice should be respected.

Regarding the Kristeller maneuver, it "should not be performed in the second stage of labor."[3,18] It "disrupts uterine contractility, produces uterine hypertonia, affecting fetal vitality; it can cause premature placental abruption and amniotic fluid embolism."[14] Despite the recommendation for not performing this practice, our study presented 2.98% of deliveries with this maneuver. This rate is lower than that from other studies

reporting 13.6% in 2016[9] and 36.1% for all women.[11] Although our study presented a lower incidence of this practice when compared to other studies, it is important to emphasize that it should be completely eliminated from childbirth assistance, since it can cause physical trauma and risk the life of both the mother and the baby.

The studied maternity hospital is part of the group of 97 hospitals that participate in the ‘Apice On’ project, which may have influenced the results found in this study; besides, it trains new professionals, so it must always adopt practices based on scientific evidence. Also, its obstetric nursing professionals act in partnership with perinatal health residents, who provide labor care in this institution.

CONCLUSION

This study showed that in most cases, the use of certain care practices at the time of delivery was based on scientific evidence, which is beneficial for both the mother and the baby. However, a prohibited practice – Kristellers maneuver – is still performed. Also, a high number of cases used synthetic oxytocin during labor and the lithotomy position. These aspects disagree with scientific evidence and must be eliminated from the practice.

This study provided a better understanding of the practices used in the assistance to natural childbirth in the studied maternity hospital, guiding the provision of care based on scientific evidence and the humanization policy. The results of this study can drive changes in care provision, since they are able to stimulate the multidisciplinary team towards the use of the best scientific evidence in their practice and the population by providing relevant information about assistance to natural childbirth.

Our study limitation refers to incomplete records from which data were collected but, in general, it was compensated by the large sample.

Regular monitoring of care practices is recommended, since scientific evidence and attention must maintain the same line of care.

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RECEIVED: 05/27/2020
APPROVED: 12/01/2020
PUBLISHED: dec/2021