Cogitare Enfermagem
ISSN: 1414-8536
ISSN: 2176-9133
Universidade Federal do Paraná

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Cogitare Enfermagem, vol. 23, núm. 4, e53258, 2018
Universidade Federal do Paraná

DOI: https://doi.org/10.5380/ce.v23i4.53258

Disponível em: https://www.redalyc.org/articulo.oa?id=483660655015

Original article

OBSTETRIC PRACTICES ADOPTED BY A PUBLIC MATERNITY IN RIO BRANCO-AC*

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ABSTRACT: Objective: To identify the obstetric practices used in childbirth and birth care in a public maternity hospital in Rio Branco, Acre. Method:Descriptive exploratory cross-sectional study with 460 women who had vaginal deliveries and their newborns from November 2013 to February 2014. Data was collected through interviews, medical records and documentation related to the newborn and submitted to descriptive and statistical analysis.Results:Demonstrably useful practices: Presence of a companion 400 (87%); use of a light diet 349 (75.9%); freedom of position and movement 374 (81.3); use of partograph forms in 246 (53.5%); pain relief 360 (78.3%) and skin to skin contact 433 (94.1%). Inappropriate practices: Amniotomy 249 (54.2%). Clearly harmful practices: oxytocin infusion 87 (39%), horizontal position during fetal expulsion 435 (94.6%), Kristeller maneuver in the expulsionperiod 71 (15.5%).Conclusion:The obstetrical model currently used can be abandoned, but this involves support to the training of health professionals.
DESCRIPTORS: Humanized birth; Obstetric nursing; Labor; Humanization of care.

PRÁTICAS OBSTÉTRICAS DE UMA MATERNIDADE PÚBLICA EM RIO BRANCO-AC

RESUMO: Objetivo: identificar as práticas obstétricas na assistência ao parto e nascimento em uma maternidade pública de Rio Branco, Acre. Método: estudo descritivo exploratório de delineamento transversal, com 460 puérperas de partos vaginais e de seus recém-nascidos ocorrido de novembro de 2013 a fevereiro de 2014. Dados coletados por meio de entrevistas, prontuário e folha de admissão do recém-nascido, submetidos à análise estatística descritiva e analítica. Resultados: práticas demonstradamente úteis: Presença de acompanhante 400(87%); oferecimento de dieta 349 (75,9%); liberdade de posição e movimento 374 (81,3); uso de partograma 246 (53,5%); alívio da dor 360 (78,3%) e contato pele a pele 433 (94,1%). Práticas inapropriadas: Amniotomia 249 (54,2%). Práticas claramente prejudiciais: infusão de ocitocina 87 (39%), posição horizontal para o parto 435 (94,6%), manobra de Kristeller no período expulsivo 71 (15,5%). Conclusão: é possível romper com o modelo obstétrico praticado atualmente, porém incentivos na formação dos profissionais se fazem necessários.
DESCRITORES: Parto humanizado; Enfermagem obstétrica; Trabalho de parto; Humanização da assistência.

PRÁCTICAS OBSTÉTRICAS DE UNA MATERNIDAD PÚBLICA EN RIO BRANCO-AC

RESUMEN: Objetivo: Identificar las prácticas obstétricas en la atención del parto y nacimiento en una maternidad pública de Rio Branco, Acre. Método: Estudio descriptivo exploratorio de delineamiento transversal, con 460 puérperas de partos vaginales y de sus recién nacidos, realizado entre noviembre de 2013 y febrero de 2014. Datos recolectados mediante entrevistas, historia clínica y hoja de admisión del recién nacido, sometidos a análisis estadístico descriptivo y analítico. Resultados: Prácticas decididamente útiles: Presencia de acompañante 400 (87%); ofrecimiento de dieta 349 (75,9%); libertad de posición y movimiento 374 (81,3%); uso de partograma 246 (53,5%); alivio del dolor 360 (78,3%) y contacto piel a piel 433 (94,1%). Prácticas inadecuadas: Amniotomía 249 (54,2%). Prácticas decididamente perjudiciales: infusión de oxitocina 87 (39%); posición horizontal para el parto 435 (94,6%); maniobra de Kristeller en fase de expulsión 71 (15,5%). Conclusión: Es posible abandonar el modelo obstétrico actual, resultando necesarios incentivos en la formación de profesionales.
DESCRIPTORES: Parto Humanizado; Enfermería Obstétrica; Trabajo de Parto; Humanización de la Atención.

*Article extracted from the masters dissertation: "Care to childbirth and birth in a SUS Maternity Hospital, in the capital of the state of Acre". Universidade Federal de São Paulo, 2014.

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Received: 14/06/2017
Finalized: 03/10/2018

http://dx.doi.org/10.5380/ce.v23i4.53258

INTRODUCTION

It has been long believed that childbirth and birth are only safe when accompanied by medical professionals, considered the central elements of a process more focused on physiological aspects than on the needs of the mothers and their children[1].

According to the World Health Organization (WHO), there is scientific evidence that various practices implemented during pregnancy and delivery generate better obstetric outcomes, with a positive impact on perinatal outcomes. Many complications that occur during the childbirth and birth process can be avoided with appropriate obstetric care and the appropriate use of technology[2]. Inadequate use of technologies and interventions mayresult in adverse outcomes for both the mother and the infant[2–4].

In an attempt to improve obstetric care, laws, programs, and official incentives were created to promote humanized and safe care. The most recent strategy, the *Rede Cegonha* program, was launched in 2011, by Brazil's Ministry of Health (MS) [5].

Therefore, the present study aimed to identify the obstetric practices used by a public maternity hospital in the capital of the state of Acre and find out whether such practices are carried outaccording to the recommendations of the WHO and the Ministry of Health.

METHOD

Descriptive and exploratory study with cross-sectional design on obstetric care provided to women during childbirth and birth in a SUS maternity hospital, in the city of Rio Branco, in the state of Acre, from November 2013 to February 2014.

The study sample included all women who had vaginal births, withliving or dead neonates weighing ≥ 500g at birth and/or with gestational age ≥ 22 weeks gestation. Of these, 460 women accepted to participate in the study. The subjects who did not understand the Portuguese language, who had special needs or were disabled (which made it impossible for them to answer the interview questions) were excluded.

Completion of the research instrument (questionnaire) wasbased on information obtained in structured interviews and data collected from maternity cards and hospital documentation of the mothers and their newborn babies. This tool was adapted from the study "Reproductive Health of Primigravidae Mothers: Analysis of factors related to the type of delivery" [6].

Obstetric practices were analyzed according to the classification adopted by the Ministry of Health in 2001, which was based on the 1996 classification of the WHO [7].

Absolute values and frequencies were calculated to obtain the qualitative (categorical) variables. Normally distributed quantitative variables were expressed as means and standard deviation, oras median (1st quartile - 3rd quartile), minimum and maximum values when Gaussian distribution did not fit the data.

Data were entered in Excel 2010 spreadsheets. Statistical analysis was performed using the SPSS 16.0 software and STATA/SE 13.0 software was used for generalization of the Fisher's Exact Test.

The present study complied with the ethical principles of Resolution No. 466/12 of the National Health Council and was approved by the Research Ethics Committee on July 5, 2013, under protocol no. 319.809.

RESULTS

The practices recommended by the WHO and the Brazilian Ministry of Health were observed. The most useful practices that should be stimulated were fluid intake during childbirth while women were

admitted to the pre-delivery, delivery and postpartum (PPP) room, reported by 349 (75.9%). Regarding the presence of a companion, 400 (87%) women said they stayed with their companions during admission in the maternity ward.

Regarding physical activity, 201 (43.7% participants reported having spent most of the time lying in bed. On the other hand, 374 (81.3%) said they had been advised to stand up and change their position, 360 (78.3%) were advised to do exercises and walking was the preferred exercise: 317 (88.1 %). Also, 245 (68.1%) exercised with a birthball, and warm shower aspersionused by 227 (63.1%) pregnant women. The least performed exercise was the stool with inverted seat ("cavalinho"): 102 (28,3%), and 231 respondents received comfort massage during childbirth.

Administration of oxytocin in the third stage of labor was reported in 421 (90%) of the respondents (Table 1).

Table 1 – Numerical and percentage distribution, practices in normal delivery considered useful and that should be encouraged, according to the WHO. Rio Branco, AC, Brazil, 2014

Practices in normal childbirth considered useful and that should be encouraged		**N**	**%**
During childbirth in the hospital was allowed to take fluids	Yes	349	75.9
	No	104	22.6
	Not informed	7	1.5
Had a companion during childbirth and birth	Yes, both in childbirth and birth	400	87
	Yes, only in childbirth	4	0.9
	No, because I did not know it was possible or because I did not want	19	4.1
	No, because there was nobody available	37	8
The companion was someone of her choice (n 404)	Yes	345	85.4
	No	59	14.6
Stayed most of the time in the bed during labor	Yes	201	43.7
	No	259	56.3
Was encouraged during labor to walk and change position	Yes	374	81.3
	No	86	18.7
Was advised during labor to do exercises	Yes	360	78.3
	No	100	21.7
Guided exercises	Walking	317	88.1
	Birth ball	245	68.1
	Comfort massage	231	64.2
	Bath	227	63.1
	Stool	102	28.3
Partograph completed	Yes	246	53.5
	No	214	46.5
Partograph fully recorded (n 246)	Yes	105	42.7
	Partially	141	57.3
Use of oxytocin after placental expulsion	Yes	421	91.7
	No	39	8.3
	Not informed	12	2.6

Enema was not used in routine care before delivery in any of the participants (460). This practice was abolished in the hospital.Trichotomy was performed in 415 (90.4%) women. However, most of them 405 (88%) performed the procedure at home; 223 (48.5%)were given intravenous infusion; of these, 87

(39%) did not know whether the injection contained or not a medicine, and most (62.3%) ignored the reason why they were given the IV fluids.

As for the positions during the expulsion period, the most frequently adopted were lying down and semi-sitting: 218 (47.4%) and 217 (47.2%), respectively.Most women said they did not need to use any intervention to facilitate fetal expulsion: 380 (82.6%). The use of Kristeller maneuver in the expulsion period was mentioned by 71 (15.5%) of them. The practice of episiotomy was mentioned by 127 (32.8%) of the respondents (Table 2).

Table 2 – Numerical and percentage distribution of practices in normal birth, clearly harmful or ineffective and that should be eliminated, according to the WHO Rio Branco, AC, Brazil, 2014

Clearly harmful or ineffective practices in normal childbirth that should be eliminated		**N**	**%**
Trichotomy	Yes, at home	405	88
	Yes, in the hospital	11	2.4
	No	44	9.6
Venous catheterization during labor	Yes	223	48.5
	No	235	51.1
	Not informed	2	0.4
Intravenous solution with medicine to increase contractions(N 223)	Yes	87	39
	No	26	11.7
	Does not know/Did not answer	110	49.3
Reason for use of intravenous solution (N 223)	Weak uterine contractions	73	32.7
	Slow labor progress	5	2.3
	To facilitate neonate expulsion	1	0.4
	Others	5	2.3
	Doesn't know/Did not answer	139	62.3
Position during delivery	Lying	218	47.4
	Half-sitting	217	47.2
	Sitting	18	3.9
	Squatting	2	0.4
	Others (hands-and-knees and standing)	5	1.1
Use of intervention in the expulsion period	No	380	82.6
	Kristeller maneuver	71	15.5
	Vacuum extraction	5	1.1
	Kristeller maneuver and vacuum extraction	1	0.2
	Vacuum extraction and forceps	1	0.2
	Not informed	2	0.7
Episiotomy/Episiorrhaphy (N 451)	No	303	67.2
	Yes	127	32.8
	Not informed	9	0.2

The study found that artificial rupture of the amniotic membranes was used in 54.2% of the respondents; of these, 30.7% had cervical dilatation less than or equal to 5 cm during the rupture of the amniotic membranes. Regarding the use of anesthesia during labor, in most cases local anesthesia was injected in the perineal region (59.8%) (Table 3).

Table 3 – Numerical and percentage distribution according to the recommendations of the WHO for normal delivery practices often used inappropriately. Rio Branco, AC, Brazil, 2014

Normal delivery practices that are often inappropriately used		**N**	**%**
Rupture of amniotic membranes	Was artificially ruptured	249	54.2
	Spontaneously	162	35.2
	No, the membrane was ruptured before the woman arrived at the hospital	37	8
	Does not know	12	2.6
Cervical dilation after rupture of the amniotic sac	≤ 5 cm	111	30.7
	6-7 cm	75	20,7
	8-9 cm	137	37.8
	10 cm	39	10.8
Anesthesia during labor and delivery	Yes, on the perineum	275	59.8
	Yes, on the back	5	1.1
	No	178	38.7
	Yes, general	2	0.4
Revision of uterine cavity after childbirth	Inspection of the vulva	447	97.2
	Manual exploration	5	1.1
	Not informed	8	1.7

Regarding physical contact with the babies, 433 (94.1%) mothers and their babies were in skin-to-skin contact immediately after birth, and 392 (85.2%) mothers were advised to breastfeed in the hospital, and it took them an average of ten minutes to breastfeed their babies for the first time. Of the newborns, 407 (88.5%) stayed with their mothers throughout the hospitalization period (Table 4).

Table 4 – Numerical and percentage distribution based on recommendations of the WHO, according to newborn care practices, AC, Brazil, 2014

Newborn care practices		**N**	**%**
Newborn was placed skin to skin with the mother	Yes	433	94.1
	Yes, but for a short time	19	4.1
	No	8	1.8
At the hospital, the mother was advised on breastfeeding	Yes	392	85.2
	No	68	14.8
How many minutes after delivery did the pregnant woman breastfeed for the first time? (N=423)	Median (1st quartile – 3rd quartile)	10 (5 – 30)	
	Minimum – Maximum	1 – 1320	
Room where the newborn was kept after delivery	With the mother	407	88.5
	At the ICU or in the nursery	26	5.6
	Sometime with the mother and sometime in the nursery	15	3.3

DISCUSSION

Fasting during labor is traditionally recommended to minimize anesthesia-related risks. Food restriction is still prescribed to women shortly before childbirth in some health institutions (in Goiânia, 62% of pregnant women were prescribed a zero diet) [8]. In the present study, the respondents confirmed that they were totally free to eat during labor. Therefore, dietary restrictions are not part of the routine of the institution.

The presence of a companion is one practice that should be stimulated and is incorporated into the routine of the institution investigated. 87% of the women had a companion during the parturition process, according to Law 11,108 of April 7, 2005[9], which conferred to pregnant women the right to a companion of their choice during labor , delivery and in the postpartum period.

Several studies have shown that the presence of the companion provides benefits to the mother-child binomial (10). However, the nationwide Birth in Brazil survey showed that only 18.8% of the women had he presence of companion continuously while in the maternity ward [11].

The use of non-pharmacological methods for pain relief are measures that promote comfort by increasing pain tolerance during the labor process, allowing the woman to participate actively in this process [2,12] These include walking, use of a birth ball, comfort massage, warm shower aspersion bath and stool with inverted seat.

Exercising and walking are practices that should be stimulated in labor[2]. In this study, although ambulation was widely stimulated, 374 (81.3%) had poor adherence, only 201 (43.7%) of the puerperal women adhered to the practice. A study on the effects of ambulation on labor has shown that it provides benefits to both mother and fetus as facilitates uterine contractions, blood flow in the uterine placenta, improves fetal oxygenation, reduces pain perception and labor duration [13].

This study also demonstrated that the distance covered by pregnant women during the active phase of labor also exerts a great influence on the length of labor evolution [13]:

> [...] the distance walked in the first three hours of the active phase of labor was associated with a reduction in the duration of this phase. This reduction was 22 minutes, 10 minutes and 6 minutes every 100 meters in the first, second and third hours, respectively, pointing to an average reduction of 2.04 hours, 1.67 hours and 1.34 hours, respectively, in the first three hours of the active phase of labor [...]

A systematic review published in 2013 on delivery positions found that labor lasted one hour less for women who were upright compared to those who had been supine or lying on their side [13-14]

The Ministry of Health strongly recommends that women exercise themselves during labor as a non-invasive, non-pharmacological measure for pain relief [2,7,13-14]. The authors believe that these measures can reduce and postpone the use of drugs in pain control, provide conditions for obtaining the collaboration of the mothers, and the companions can also participate[2].

The use of a birth ball has been strongly recommended for the facilitation of the labor process (15). In the present study, the ball was adopted by 70% (245) of the respondents. It promotes directing the pregnant woman to the upright position, facilitating the movement of the pelvis and working the muscles of the pelvic floor [16]. A randomized controlled trial (RCT) in two groups of women with the same obstetric characteristics showed that the group of women who performed exercises with the ball experienced grater pain relief compared to the group of women who did not perform such exercises, although the referred exercised did not impact the duration of labor childbirth evolution[15]. Another study conducted in Hong Kong and a systematic review with meta-analysis of three RCTs corroborate this finding [17-18].

Regarding the comfort massage, in this study 231 (64%) of the respondents reported having received comfort massage during labor. In a systematic review [19], four RCTs reported the use of massage done by a midwife and the companion, which is more effective when used at the beginning of the latent phase. It reduces stress and anxiety levels caused by pain, promoting the active participation of the companion, improving the satisfaction of both, which corroborates a study [19-20].

Another non-pharmacological practice was the shower bath, which was reported by 227 (63%) participants. Studies have shown that a warm shower is a simple non-pharmacological measure that promotes relaxation and comfort during childbirth[12,21-22]. Also, taking a warm shower when cervical dilation is 8-9 cm has proven to be effective in the relief of pain [22] Thus, the combination of two or

more non-pharmacological methods proved to be even more effective in relieving pain and discomfort during labor than the combination of bath and exercises with a birth ball [16].

The partograph (or labor chart) is widely used to monitor the progress of labor. According to the WHO, the use of partographs allows monitoring the evolution of labor indicating the appropriate measures to be taken to correct deviations and avoiding unnecessary interventions [2].

A study conducted in 13 maternity hospitals in Goiânia, Brazil, with 404 women who had normal birth, found that partographs were attached only to the medical records of 28.5% of the participants, and in 13% of these medicals records there were no notes [8] Another study conducted in a maternity hospital in the city of São Paulo showed that, although partographs were attached to nearly 80% of the medical record, in many cases (77%), this tool was incorrectly used[23].

This study found partographs in 246 (53.5%) medical records. Of these, only 141 (57.3%) were partially completed and such data was not assessed. Despite the undervaluing of this tool, the partograph is effective and necessary for the monitoring of the evolution of labor.

Enema, trichotomy and administration of IV fluids are clearly harmful or ineffective practices that should be eliminated. A systematic review on pubic trichotomy during labor found that there is no evidence to recommend its routine use [7].

In the present study, we did not identify the use of enema and trichotomy in an in-hospital environment. However, trichotomy seems to be a cultural habit of women, since most of them shave pubic hair at home (88%) as part of the preparation for delivery before going to the hospital.

Regarding intravenous infusion of fluids and uterotonic agents, 223 (48.5%) women received IV fluid infusion, and 139 (49.3%) were unaware of the reason for the infusion. Of these IV infusions, 87 (39%) were used for the administration of uterotonic agents, although these have proven to be ineffective and should be eliminated [2,7], These harmful practice continues to be widely used in Brazilian maternity hospitals: the Birth in Brazil survey showed that 70% of the women used IV solutions during labor, and in 40% of the cases the solutions include uterotonic agents [11].

Although it is not recommended for routine use, amniotomy has been used as part of the active management of labor by some medical schools[2,7].

A systematic review associated amniotomy with an increased incidence of caesarean section [24]. In this study, amniotomy was performed in 249 (54.2%) of the women. Of theses, 162 (30.7%) had cervical dilation of 5 cm or less. The use of amniotomy is controversial and differs in the different Brazilian maternity hospitals. In a national survey, amniotomy was found in 39% of the deliveries[4] whereas a study in Belo Horizonte found a rate of 65% [25] In a study conducted in Rio de Janeiro in an obstetric center where deliveries were exclusively attended by obstetrical nurses, the rate of amniotomy was only 5.8% [26].

Recent studies have demonstrated the importance of the position of the woman during birth. For example, there is abundant evidence that the lithotomy position poses risk for both for the mother and her infant. The WHO and the Ministry of Health advise against its use [2,7]. However, for many decades, this position was considered the most adequate for the performance of hospital procedures and was considered the standard birthing position. Scientific evidence has proven that it is harmful.

However, in many maternity hospitals in Brazil the lithotomy position is routinely used, and the patients are not allowed to choose another delivery position[2,7]. A study that aimed to analyze the perineal results of deliveries performed in the upright, half-sitting and side-lying positions,concluded that there was a lower incidence of vulvar edema, episiotomy and injury to the labia where women were in a side-lying delivery position. In the upright position there was a higher risk of second-degree perineal tear [27]

A study conducted in Rio de Janeiro with 1,715 pregnant women who were attended by obstetric nurses found that episiotomies were performed in 29.1% of the cases, and the most frequent delivery position was the upright position (63.4%). In 24.3% of the cases there was first-degree laceration and in 2.4%,second-degree laceration. The percentage of lacerations in deliveries in horizontal position was: 9.4% for first-degree lacerations and only 0.7% for second-degree lacerations [28].

This study found that the most frequent delivery position was lying: 218 (47.4%) and half-sitting:- 217 (47.2%) in bed in pre-delivery, delivery and post-delivery. Thus, the horizontal position prevailed. A systematic review published by the Cochrane Library in 2012 that in traditional culture, women usually give birth in upright, kneeling, standing, or squatting positions [14].

Another clearly harmful obstetric practice, which should be eliminated, is the Kristeller maneuver, a technique that applies manual pressure to the upper part of the uterus, used in cases such as fetal distress, lack of labor progression, and maternal exhaustion. It should be discouraged because of the risks posed [8] It causes pain and discomfort, violating the right of women to their bodily integrity[25]. A study conducted in a maternity hospital in the capital of Minas Gerais reported the use of this maneuver in 9.3% of the deliveries attended by obstetrical nurses, and the national rate was 36% [25].In the present study, this practice was identified in 71 (15.5%) of the deliveries.

The occurrence of episiotomy is an important indicator of the quality of obstetric care. The most recent Cochrane evidence on the selective use of episiotomy versus routine use reveals that selective use is associated with a lower risk of severe perineal trauma, less blood loss, with little or no effect on the Apgar score [29]. It also reveals that there was no difference between the two groups regarding stress urinary incontinence, dyspareunia and perineal pain after childbirth, corroborating the recommendations of the Ministry of Health of restriction of practice [7,29].

Routine use of episiotomy is classified according to scientific evidence as a clearly harmful practice that should be eliminated [2,7].

In this study, episiotomy occurred in 127 (32.8%) deliveries, and there was no specific protocol recommending selective or routine use of this practice. Studies conducted in two different Brazilian capitals with women whose deliveries were primarily attended by obstetric nurses, showed a rate of 8.4% and 29.1% [25,28]. The Birth in Brazil survey, of 2012, found that episiotomy occurred in 56.1% of births in Brazil [11].

Skin-to-skin care and breastfeeding in the first hour of life were guidelines for the organization of comprehensive and humanized care for the newborn under the SUS, established through a ministerial ordinance[30]. The Birth in Brazil survey shows that skin-to-skin contact was restricted to 26.6% of the newborns and in only 14.7% of the cases the mothers started breastfeeding in the delivery room [11].

The present study found that skin-to-skin care prevailed, as 433 (94.1%) of the newborn babies stayed with their mothers for more than one hour, and 392 (85.2%) of these mothers were advised to breastfeed in the delivery room, and it took them in average ten minutes to breastfeed their babies for the first time.

Of the newborns that participated in this study, 407 (88.5%) stayed with their mothers throughout the hospitalization period; the others could not stay with their mothers because they required intensive care. Corroborating the results of this study, data from a study conducted in Belo Horizonte, capital of Minas Gerais, showed that early contact between mother and child in vaginal deliveries was ensured in more than 77% of the births, and more than 90% of the newborn babies had Apgar scores greater than or equal to eight [25] However, despite the fact that this and other studies demonstrated the importance of good care practices to the newborn and optimal perinatal outcomes, the Birth in Brazil survey revealed that the practice of keeping mothers and babies in the same room was performed in only 64.2% of the births [11].

One limitation of this study concerns the difficulty in identifying the professional directly responsible for care to delivery. Since these professionals did not use any type of identification that distinguished them from doctors and nurses, or even nursing technicians, it has not been possible to indicate the professional category that provided care to the women during labor or delivery. It is recommended, therefore, that health professionals use some type of identification, so that in future studies on this subject the women are able to inform the specific occupation of the health worker responsible for their care in the delivery process.

CONCLUSION

This study showed that the humanization policy implemented by the Ministry of Health and the WHO in Brazil's Unified Healthcare System (SUS) has been partially successful, since good practices and measures aimed to ensure pain relief to women during labor were routinely adopted in the institution where the study was conducted.

However, the study also found that abandoning a technocratic and interventionist model is not an easy task, that inadequate interventions are performed during care to the labor and delivery process, such as the use of solutions with oxytocin and induction with uterotonic agents, and that horizontal position in the expulsion period, use of Kristeller maneuver and episiotomy are obstetric practices that are still prevalent today.

The predominance of day-to-day practice and experience over scientific evidence reinforces the importance of involving institutions that childbirth care in the (re) structuring of their services, not only in terms of physical structure, but also in the training and qualification of their professionals, for the reformulation of old concepts, giving women the right to have a core role in decisions related to the birth practices used during the labor and delivery process.

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