

Health care in the prenatal and childbirth context from puerperal women's perspective

Atenção à saúde no contexto do pré-natal e parto sob a perspectiva de puérperas
Atención de salud en contexto de prenatal y parto desde la perspectiva de las madres

Bruna Rodrigues Monteiro^I

ORCID: 0000-0003-4714-7723

Nilba Lima de Souza^I

ORCID: 0000-0002-3748-370X

Priscilla Pâmela Silva^I

ORCID: 0000-0003-1861-7546

Erika Simone Galvão Pinto^I

ORCID: 0000-0003-0205-6633

Débora Feitosa de França^I

ORCID: 0000-0003-2624-5375

Ana Carla Alves de Andrade^{II}

ORCID: 0000-0001-5034-9129

Annelissa Andrade Virginio de Oliveira^{III}

ORCID: 0000-0001-9066-190X

^IUniversidade Federal do Rio Grande do Norte,
Natal, Rio Grande do Norte, Brazil.

^{II}Universidade Federal de Pernambuco, Recife,
Pernambuco, Brazil.

^{III}Universidade Federal da Paraíba, João Pessoa, Paraíba, Brazil.

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Corresponding author:

Bruna Rodrigues Monteiro
E-mail: brunarenfermeira@gmail.com



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ASSOCIATE EDITOR: Alexandre Balsanelli

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ABSTRACT

Objectives: to investigate puerperal women who received guidance on childbirth during prenatal care and the behaviors experienced in the labor process within the context of good obstetric practices from the perspective of puerperal women. **Methods:** a descriptive cross-sectional quantitative study conducted with 203 puerperal women admitted to the shared rooms of a teaching hospital between May and July 2017 during the immediate postpartum period. For data collection, was used an instrument adapted from the hospital questionnaire for puerperal women that was developed by the Oswaldo Cruz Foundation. **Results:** only 48.3% of puerperal women received the eight orientations regarding good obstetric practices during prenatal care, which were not experienced in the labor process, especially regarding referral and behaviors of the hospital team. Unfavorable socioeconomic conditions were significant in relation to guidelines provided during prenatal care. **Conclusions:** prenatal care was negatively evaluated and there was lack of compliance with good obstetric practices and non-recommended behaviors in the labor process in the maternity ward.

Descriptors: Health Care; Prenatal; Labor; Obstetric Nursing; Health Education.

RESUMO

Objetivos: investigar as puérperas que receberam orientações acerca do parto no pré-natal e as condutas vivenciadas no processo parturitivo, no contexto das boas práticas obstétricas, a partir da visão das puérperas. **Métodos:** estudo descritivo, transversal, com abordagem quantitativa, realizado com 203 puérperas no pós-parto imediato admitidas no alojamento conjunto de um hospital-escola entre maio e julho de 2017. Para a coleta de dados, foi utilizado um instrumento adaptado do questionário hospitalar-puérpera elaborado pela Fundação Oswaldo Cruz. **Resultados:** apenas 48,3% das puérperas receberam as oito orientações referentes às boas práticas obstétricas no pré-natal, que não foram vivenciadas no processo parturitivo, sobretudo no aspecto do referenciamento e na conduta da equipe hospitalar. As condições socioeconômicas desfavoráveis apresentaram significância em relação às orientações do pré-natal. **Conclusões:** a assistência do pré-natal apresentou avaliação negativa, com presença de condutas não recomendadas no processo parturitivo na maternidade e falta de cumprimento das boas práticas obstétricas.

Descritores: Atenção à Saúde; Pré-Natal; Trabalho de Parto; Enfermagem Obstétrica; Educação em Saúde.

RESUMEN

Objetivos: investigar a las madres que recibieron orientación sobre el parto durante la atención prenatal y los comportamientos experimentados en el proceso de parto, en el contexto de buenas prácticas obstétricas, desde la perspectiva de las madres. **Métodos:** una investigación descriptiva, transversal y cuantitativa, realizada con 203 mujeres en el posparto inmediato ingresadas en un alojamiento conjunto de un hospital escuela entre mayo y julio de 2017. Para la recopilación de datos, se utilizó un instrumento adaptado del cuestionario del hospital para madres preparado por la Fundación Oswaldo Cruz. **Resultados:** solo el 48,3% de las madres recibió las ocho orientaciones sobre buenas prácticas obstétricas durante la atención prenatal, que no fueron vividas en el proceso de parto, especialmente en relación con la referencia al hospital y la conducta del equipo del hospital. Las condiciones socioeconómicas desfavorables fueron significativas en relación con las orientaciones en la atención prenatal. **Conclusiones:** la atención prenatal se evaluó negativamente, con la presencia de conductas no recomendadas en el proceso de parto en la sala de maternidad y la falta de cumplimiento de las buenas prácticas obstétricas.

Descriptorios: Atención de Salud; Cuidado Prenatal; Trabajo de Parto; Enfermería Obstétrica; Educación en Salud.

INTRODUCTION

Obstetric care is provided to pregnant women during prenatal, delivery and postpartum. In this scenario, the presence of light technologies in prenatal health care is inherent to good obstetric practices, integrates pregnant women as the subjects of their choices in the labor process, contributes to change the obstetric model and ensures the reduction of maternal and fetal morbidity and mortality rates⁽¹⁾.

The function of prenatal care is to offer women embracement with quality since the beginning of pregnancy. This service is guaranteed by Ordinance/GM number 4559 of 2011, which established the Rede Cegonha ("Stork Network", obstetric care service for women) and held the states and municipalities responsible for parameters such as: pregnant women's access to prenatal consultations with active listening, educational activities, and the recovery of their dignity during the labor process⁽²⁻³⁾.

The lack of educational actions and guidance in prenatal consultations, especially regarding pregnant women's rights, contributes to their lack of knowledge about the labor process, which can make them vulnerable to obstetric violence, dissatisfaction in childbirth and submission to the care model adopted by the team⁽⁴⁻⁵⁾.

In this scenario, qualified prenatal care encompasses the understanding that the choice for normal delivery goes beyond pregnant women's desire, includes social aspects and depends on access to prenatal guidance. This care is provided through health practices that clarify pregnant women's doubts during consultations with their active participation in educational activities⁽⁶⁻⁷⁾.

There are also aspects related to childbirth, because the predominant obstetric care model in the Unified Health System (SUS) is characterized by the high use of interventions, especially during the labor process. Inadequate use of technologies without the parturient's explicit and informed consent triggers obstetric violence⁽⁸⁾.

In the scope of the study, between 2007 and 2016, there were Brazilian and international studies focused on obstetric violence themes. However, globally, this terminology does not have a specific concept yet, nor the necessary conducts of stimulation to women during prenatal care and the labor process. Hence, they remain submissive to the health system current model⁽⁹⁻¹⁰⁾.

Given the weaknesses of good obstetric practices offered to women in Brazil, the Ministry of Health has instituted the national guideline for normal childbirth care in SUS⁽¹¹⁾. This guideline recommends the adoption of care practices in pregnancy, childbirth and birth with use of evidence-based technologies in order to avoid exposing women and newborns to unnecessary interventions in a physiological process that represents health⁽¹²⁾. Along with this guideline, the Rede Cegonha has made maternal and child health care feasible in the country⁽¹¹⁾.

The understanding that offering fragmented care or lack of care to pregnant women during prenatal and delivery compromises the good obstetric practices in normal childbirth led to the following question: is the prenatal and delivery health team performing activities of guidance and stimulus conducts to normal delivery with pregnant women according to protocols of good obstetric practices?

OBJECTIVES

To investigate the mothers who received guidance on childbirth in prenatal care and the conducts experienced in the labor process within the context of good obstetric practices from the mothers' point of view.

METHODS

Ethical aspects

The study met the ethical recommendations of Resolution 466/2012 of the National Health Council on research with human beings and was approved by the Research Ethics Committee of the Universidade Federal de Pernambuco under number CAAE2.491.511.

Design, place of study and period

This is a descriptive, quantitative, cross-sectional study. The study took place in a shared room unit of a teaching hospital in the city of Recife/Pernambuco, Brazil, between May and July 2017. The public hospital belongs to the Universidade Federal de Pernambuco. It is a reference in the care of pregnant women in labor in the state and has 30 beds to provide multiprofessional care to puerperal women and newborns.

Population or sample; inclusion and exclusion criteria

The sample was formed from information on the frequency of normal deliveries performed at the maternity hospital provided by the epidemiology center of the institution and the monthly average was of 93 normal deliveries in 2016. The sample calculation using the finite sample formula was of 203 puerperal women for the study period, and this corresponded to the number of participants.

The inclusion criteria were puerperal women in the immediate postpartum period after normal delivery (up to 48 hours) who had prenatal care in the state of Pernambuco. Exclusion criteria included women with preterm deliveries, dead fetus and those admitted during the expulsive period.

Study protocol

The instrument used in the study was an adaptation of the hospital-postpartum questionnaire prepared by the Oswaldo Cruz Foundation in 2011⁽¹³⁾. This is a standardized instrument built for the national survey on labor and delivery in Brazil through which is possible to identify the type/reason for delivery and evaluate the care to women in the prenatal period and delivery.

For the adaptation, were considered only the questions related to the study objective, and selected topics related to women's social identification, prenatal-related variables, and decision about the type of delivery and labor process, which resulted in 35 questions extracted from the questionnaire.

Analysis of results and statistics

The collected data were inserted in spreadsheets and descriptive and inferential statistics were performed with use of the

Statistical Package for Social Sciences (SPSS), version 20.0. The Pearson's chi-square test was applied to compare proportions and bivariate analysis was used to establish the relationship between socioeconomic profile, level of knowledge, and the influence of practices in the prenatal context and parturition process.

The Mann-Whitney test was applied to compare dichotomous variables, and the Kruskal-Wallis test was applied to compare the recommendation score in variables with three or more levels. In all analyzes, was adopted a significance level of 5% ($P < 0.05$).

In the evaluation of the level of guidance received by women in prenatal care, was used the percentage score, which ranged from 0% (no practice) to 100% for postpartum women who responded positively to the eight guidelines evaluated in the study, namely: signs of risk in pregnancy that indicated search for health services; breastfeeding in the first hour of life; referral hospital for delivery; signs of onset of labor; methods to facilitate the childbirth; participation in pregnant women's group; right to a companion of their choice; and birth plan.

RESULTS

The socioeconomic and obstetric characterization of puerperal women was: age over 18 years old (89.7%), with partner (81.8%), resident in the inlands of the state (81.8%), mixed race (73.4%), unemployed (70.9%) and with more than eight years of schooling (57.1%). In the obstetric aspect, puerperal women had already experienced the labor process (58.6%), had more than six prenatal consultations in their last pregnancy (73.9%) in public health services (96.6%) and were attended exclusively by nurses (45.3%).

Regarding guidance provided during prenatal care about the labor process, there was statistical significance in the eight practices evaluated in the following order (as shown in Table 1): risk signs that led pregnant woman to seek health services; breastfeeding in the first hour of life; referral to hospital/maternity/birthing house for childbirth; signs of onset of labor; pain relief methods that facilitate childbirth (shower, ball, massage, birth chair, verticalization, ambulation); participation in pregnant women's group; right to a companion of their choice; and birth plan. On average, women were given 48.3% of the eight orientations about delivery during prenatal care, with a standard deviation of 24.4%. Good practices in labor and delivery had the lowest percentage of guidance regarding variables that strengthen women's empowerment in the labor process.

Regarding the expected birth route of women who had prenatal care since the beginning of pregnancy, there was a preference for normal delivery (73.4%), but this preference was reduced at the end of pregnancy (58.6%).

Regarding the practices performed in the labor process in the maternity ward, all data presented significance in the analyzed variables. Regarding hospitalization, pregnant women were admitted to the hospital according to prenatal referral (40.9%), as a result of hospital transfer (50.4%), by direct admission (8.7%), and with a clinical history of high blood pressure levels (63.5%).

The right to a companion was respected during pregnant women's hospitalization (99.0%) according to their choice (85.6%). The companion was present all the time (77.6%) and women considered their help was important in the comfort and quality of delivery (66.7%).

Table 1 – Guidance offered during prenatal care according to puerperal women's self-reports within the context of good obstetric practices, Recife, Pernambuco, Brazil, 2017

Guidance offered	Practices performed		p value
	No	Yes	
Signs of risk that lead pregnant woman to seek health services	46 (22.7%)	157 (77.3%)	<0.001
Breastfeeding in the first hour of life	65 (32.0%)	138 (68.0%)	<0.001
Referral for hospital/maternity/birthing house for delivery	66 (32.5%)	137 (67.5%)	<0.001
Signs of onset of labor	80 (39.4%)	123 (60.6%)	0.003
Pain relief methods that facilitate the birth of baby	109 (53.7%)	94 (46.3%)	0.04
Participation in pregnant women's group	143(70.4%)	60 (29.6%)	<0.001
Right to a companion of their choice	145(71.4%)	58 (28.6%)	<0.001
Birth plan	185(91.1%)	18 (8.9%)	<0.001

Note: ¹p-value of chi-square test for comparison of proportions (if p-value<0.05, percentages of the evaluated factor levels differ significantly).

Table 2 – Association between guidance offered during prenatal care and the socioeconomic profile, Recife, Pernambuco, Brazil, 2017

Variables	Mean±Standard deviation	p value
Race		
White	45.3±24.4	0.016 ²
Black	35.3±22.2	
Mixed race	50.6±24.2	
Source of income		
No	46.1±24.6	0.040 ¹
Yes	53.8±23.2	
Marital status		
No partner	49.8±24.2	0.051 ¹
With partner	41.9±24.7	

Note: ¹p-value of the Mann-Whitney test; ²p-value of the Kruskal-Wallis test.

The food supply during labor was present during care (52.2%), but respondents who used magnesium sulfate (12.8%) during labor had restrictions in their diet. Non-pharmacological pain relief methods were used to facilitate birth during the labor process (80.8%) with focus on induction methods. Some parturients also used oxytocin (42.9%), amniotomy (34%) and misoprostol (33%).

During the expulsive period, women were attended by doctors (49.3%) and they reported the lack of identification of the professional who provided care (15.3%). In this phase, parturients were transferred to another room (74.9%), adopted the semi-seated position (91.6%), experienced non-instrumental delivery (98%) and spontaneous lacerations that were sutured (57.7%).

The association of practices experienced in prenatal care and the labor process was investigated in comparison with the socioeconomic and obstetric profile and practices performed in the hospital unit.

When analyzing the socioeconomic factors, it was evident, as shown in Table 2, that skin color/race, income and marital status of puerperal women were statistically significant when associated with guidance offered during prenatal care, and there was a positive influence on puerperal women of mixed-race with source of income and partner.

When associated with prenatal guidance, the other socio-economic and obstetric factors were not significant, nor influenced

by the consultation environment. A higher average percentage of guidance was observed in women with ≥ 6 prenatal consultations (48.9), who attended prenatal care in public and private services (56.2), had nurses as professionals responsible for the consultation (50.5), and were monitored by these professionals most of the time (48.5).

There was no statistical significance when associating the guidance offered in prenatal care and practices experienced in childbirth. However, women who received guidance during prenatal care presented a higher average value for the absence of a companion (81.2), needed to seek assistance in more than one maternity ward (55.2), experienced an instrumental delivery (62.5), and did not use pain relief methods to facilitate childbirth (51.3).

DISCUSSION

In the socioeconomic aspect, data showed that black women with unfavorable socioeconomic status were those who received less guidance on good obstetric practices in normal delivery during prenatal care. Similar results were found in studies that reported a lack of guidance on the signs of pregnancy risk among women of low socioeconomic status⁽¹⁴⁾, lack of prenatal guidance on signs of onset of labor for black women⁽¹⁵⁾, and race and low socioeconomic status as factors of stigma and discrimination during pregnant women's prenatal care and delivery⁽⁹⁾.

Unequal care as a result of socioeconomic factors violates the SUS doctrinal principles of equity, universality and comprehensiveness⁽¹⁶⁾, and affects the right to equality and justice of women undergoing prenatal care.

Although overall results point to a negative evaluation of guidance on good practices for stimulating normal delivery during prenatal care, women who were continuously monitored by the same health professional, in this case the nurse, and performed more than six prenatal consultations, had a higher average percentage of information on the subject⁽¹⁷⁾. However, studies indicate that practices for stimulation of normal birth in primary care are still unsatisfactory, as women reported lack of information about normal labor, and associated it with a painful and unbearable process. Furthermore, when available, such information was provided inaccurately and insufficiently⁽¹⁸⁾.

Despite the high coverage of prenatal care in the Brazilian territory, more than 90% of women experienced practices to induce normal birth inappropriately⁽¹⁹⁻²⁰⁾. Although northeastern Brazil has the largest population coverage in primary care (84%), the region also has unfavorable results related to the guarantee of quality and effective functioning of prenatal care⁽²¹⁾.

Prenatal consultations allow that professionals and pregnant women exchange experiences and knowledge about the process of good obstetric practices, and this can be developed through pregnant women's groups^(5,19,22).

Adopting a birth plan may be a favorable factor for good obstetric practices, even though low rates of this practice have been identified in this study. The birth plan is a technology in favor of pregnant women and can be performed by primary care nurses, but it is still an unknown right of women undergoing prenatal care⁽²³⁾. When present, the birth plan provides guidance for pregnant women on pain relief methods that facilitate childbirth and autonomy, place of birth, opinion about the use of induction and feeding methods,

and favors a positive outcome in labor and performance of skin-to-skin contact in the first hour of newborns' life⁽²⁴⁾.

The frequency of women who performed prenatal care and still chose cesarean delivery at the end of pregnancy was considerable. Situations that commonly favor this decision are uncertainties about the safety of the newborn during pregnancy, the lack of dialogue with the professional about pregnancy, the lack of support from family and institution, and the influence of the sociocultural dimension, besides women's comfort and feelings during the labor process^(4,18).

Pregnant women searched for care in other maternities (not the reference) as a result of some complications, especially high blood pressure levels. This fact portrays a Brazilian reality, in which negative history in the prenatal period or cases of risk for new negative outcomes face difficulties with attendance at referral services, and consequently, women engage in a crusade to find a maternity ward^(14,20).

Among inconsistent factors with good obstetric practices, even for women who received prenatal guidance, were the presence of induction methods for childbirth, lack of identification by professionals, changing the bed for delivery, adoption of the semi-seated position, suture in spontaneous lacerations and the difficulty of communication between primary care and hospital care teams. These situations confront the best practices recommended in guidelines for the organization of health care during pregnancy in a maternity ward^(11,16).

When adopting the semi-seated position, parturients presented higher frequency of development of vulvar edema (29.9%) and episiotomy-focused intervention (35.1%). Despite the existence of induction methods, the aforementioned are still on a smaller scale compared to others with values above 50% of intervention⁽²⁵⁾.

In the face of a complex childbirth, even being a high-risk service, the recommended guideline is encouraging normal childbirth in all phases of the process in the same environment and in positions that offer greater comfort to women⁽¹⁶⁾.

In the labor process, the results showed respect for women's rights regarding the presence of a companion of their choice. The companion contributes to emotional support, brings safety, comfort and reduces fear⁽²⁶⁾. The absence of a companion in labor contributes to the greater use of unnecessary interventions in parturient women, and reinforces the principles that the companions' presence negatively interferes with the labor process and reduces women's empowerment^(9,27).

Another highlighted factor that affects good obstetric practices involves the communication between professionals and women⁽⁹⁾. In the present study, the main professionals responsible for the delivery were physicians, and women reported lack of self-identification by these professionals, which compromises the communication between them and users.

The lack of identification by professionals who provide care generates nervousness and lack of information for pregnant women and their companions about the evolution of childbirth, undermines the interpersonal relationship between the woman, the companion and the professional, endangers the empathic support in the labor process, and compromises the quality of care⁽²⁸⁻²⁹⁾.

Therefore, the presence of interventions during the labor process, even though women have experienced good prenatal

practices, seems to reflect the present biomedical model. This model devalues pregnant women's autonomy and protagonism, and shows the absence of beds, poor organizational structure of the physical environment of institutions and untrained human resources to assist women in the process, which result in harmful or ineffective practices^(9,26).

In general, in the associations of variables, women with more guidance on good obstetric practices during prenatal care were those who experienced non-recommended practices during delivery. Such a situation may be related to women's vulnerability during labor. When they cannot find a favorable environment to resort to, shaped by technology and intervention, they tend to repress their rights in order to avoid complications in the care provided for them and their child^(4,6).

Limitations of the study

Data collection took place at the institution where puerperal women gave birth, and the study was conducted only after their admission to the maternity ward as a way of not restraining their position regarding the care provided during childbirth. The scarcity of questionnaire instruments containing variables of good obstetric practices that should be provided in prenatal care and experienced during the labor process may also have hindered the insertion of variables related to the theme.

Contributions to Nursing, Health or Public Policy

The study has a pioneer character because the guidance received in prenatal care and the behaviors experienced in the labor process were investigated quantitatively in the same group of women in relation to good obstetric practices in a high complexity service. Therefore, it supports discussions on the reason for the low percentage of recommendations during prenatal care

for women's empowerment and their protagonism during the labor process in the hospital, which enables new studies portraying the broader context of obstetric care. In addition, the study raises a reflection on the role of nurses in this labor process, as their performance goes beyond primary care and hospital care.

CONCLUSIONS

The study shows that prenatal care had a negative evaluation in the aspects of guidance and empowerment of pregnant women regarding compliance with good obstetric practices. The unfavorable care of maternity hospitals also reinforced the use of non-recommended behaviors in labor and humanized normal delivery.

The influence of socioeconomic factors in care favored the experience of non-recommended, inappropriate and harmful practices to normal and humanized childbirth. Such factors included economically underprivileged women, black women, lack of communication between professionals and pregnant women, structural problems of lack of beds and, above all, the predominance of the hegemonic model during the labor process characterized by the transference of parturient women at the time of delivery and the adoption of the semi-seated position.

A reflection on the conduct adopted by health professionals both in prenatal care and maternities is urgent, with a view to women's empowerment in their reproductive rights for the reduction of unnecessary interventions and promotion of the quality and safety of childbirth.

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