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The contribution of nurse midwives to consolidating humanized childbirth in maternity hospitals in Rio de Janeiro-Brazil

Contribuição de enfermeiras obstétricas para consolidação do parto humanizado em maternidades no Rio de Janeiro-Brasil

Contribución de enfermeras obstétricas para la consolidación del parto humanizado en maternidades en Río de Janeiro-Brasil

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Abstract

Introduction: Since their insertion in the delivery rooms of public hospitals, nurse midwives have striven for humanized care in childbirth. **Objectives:** To identify the practices employed by nurse midwives in childbirth care in public hospitals and their contribution to the consolidation of humanization of childbirth. **Methods:** A descriptive, quantitative, cross-sectional, study, held in maternity hospitals of the public health system in Rio de Janeiro, evaluating records of 4,787 childbirths, of which 2,914 (59.73%) were attended by nurse midwives. **Results:** In Maternity Hospital *A*, 68.50% of childbirths were attended by nurse midwives, while in Maternity Hospital *B*, the figure was 43.07%. The adoption of upright positions was predominant (78.95%). Encouraging walking occurred in 37.29% of deliveries. Episiotomy occurred only in 4.0% of childbirths. **Conclusions:** The most frequent practices were those that do not negatively influence the physiology, contributing to the humanization. The occurrence of interventionist practices represents an ongoing process of change.

Keywords: Obstetric nursing; Humanizing Delivery; Women's Health; Medicalization.

Resumo

Introdução: Desde sua inserção nas salas de parto de maternidades da rede pública, enfermeiras obstétricas vêm empenhando-se por uma assistência humanizada ao parto. **Objetivos:** Identificar as práticas empregadas por enfermeiras obstétricas na assistência ao parto em maternidades públicas e sua contribuição na consolidação da humanização do parto e nascimento. **Métodos:** Estudo descritivo, quantitativo, transversal, conduzido em maternidades da rede pública municipal do Rio de Janeiro, onde foram avaliados registros de 4.787 partos, dos quais 2.914 (59,73%) foram acompanhados por enfermeiras obstétricas. **Resultados:** Na Maternidade *A*, 68,50% dos partos foram acompanhados por enfermeiras obstétricas. Na Maternidade *B*, estes foram 43,07%. Predominou a adoção de posições verticalizadas (78,95%). O estímulo à deambulação ocorreu em 37,29% dos partos. A episiotomia ocorreu em apenas 4,0% dos partos. **Conclusões:** As práticas mais utilizadas foram aquelas que não interferem na fisiologia, contribuindo para a humanização. A presença de práticas intervencionistas reflete um processo ainda em transformação.

Palavras-chave: Enfermagem obstétrica; Parto humanizado; Saúde da mulher; Medicalização.

Resumen

Introducción: Desde su inserción en las salas de parto de los hospitales públicos, enfermeras obstétricas están luchando para una atención humanizada en el parto. **Objetivos:** Identificar las prácticas empleadas por enfermeras obstétricas en la atención del parto en hospitales públicos y su contribución a la consolidación de la humanización del parto. **Métodos:** Estudio descriptivo, cuantitativo, transversal, desarrollado en maternidades públicas en Río de Janeiro. Se evaluó los registros de 4.787 partos, de los cuales 2.914 (59,73%) fueron atendidos por enfermeras obstétricas. **Resultados:** En la Maternidad A, 68.50% de los partos fueron atendidos por enfermeras obstétricas y en la Maternidad B 43,07%. La adopción de posiciones verticales fue predominante (78,95%). El estímulo para caminar ocurrió en 37,29% de los partos y la episiotomía en 4,0%. **Conclusiones:** Las prácticas más frecuentes fueron las que no interfieran en la fisiología, contribuyendo en la humanización. La ocurrencia de prácticas intervencionistas representa un proceso de transformación.

Palabras clave: Enfermería obstétrica; Parto humanizado; Salud de las mujeres; Medicalización.

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INTRODUCTION

The care of the nurse midwife requires commitment and responsibility not to intervene, and to renounce the wish for power, in favor of achieving comprehensive health care for women,[1] an achievement which arose in a Brazilian context characterized by democratization and social participation, within a more humanitarian conception.[2]

In the mid-1980's, the interventionist obstetric practices undertaken in maternity hospitals began to be characterized by authoritarianism and by the poor quality of scientific evidence, and showed practical unsustainability, unsafeness, and inefficacious need.[2] At that time, the work of the nurse midwife had, as its primary merit, the intensive surveillance and control of labor. It was after the Open Public Examination of 1985 that nurse midwives also began to work in direct assistance with birth, which had previously been the exclusive territory of the physicians, in the ambit of the hospitals of Rio de Janeiro's Municipal Health Department. This occurrence represented the breaking of the medical hegemony, and awoke in the users of the Unified Health System (SUS) both knowledge of and a wish for less interventionist practices.[2]

In the beginning of the 1990s, the municipality of Rio de Janeiro underwent a process of municipalization of the federal maternity hospitals and, concomitantly, the movement for the humanization of labor and birth spread across Brazil.[3] As a reflection of this, changes were observed in the political actions directed towards the Brazilian obstetric field in relation to encouraging normal birth. These actions led to the insertion of nurse midwives in the maternity hospitals from 1998 onward, followed by the inauguration of the other maternity hospitals geared towards the prioritization of humanized care for birth.[3]

Even with the significant changes achieved in the obstetric field, Brazil continues - statistically - to have one of the highest rates of cesareans, reaching 51.9%.[4] Equally significant are the rates for interventions in childbirth care, especially amniotomy, endovenous infusion of synthetic oxytocin, intrapartum analgesia, episiotomy and the Kristeller maneuver.[4] Brazil also figures as one of the countries with the highest rates of maternal death,[4] and the World Health Organization (WHO) invests in the inclusion of nurse midwives in direct care for birth in order to combat these rates and to comply with the governmental authorities' recommendations.[2] As a result of this, the nurse midwife has come to be recognized for reinventing less unequal relationships and aggregating to de-medicalized knowledge respect for the physiology of childbirth.[1,5] Nurse midwives have been shown to be professionals who know how to recognize themselves in the obstetric field and who seek, through their liberating care, to respect the dignity and autonomy of the woman.[1,5]

The present study investigates the work of the nurse midwife in public maternity hospitals of Rio de Janeiro, whose work is based in the legal provisions under Law N. 7498/86 and Decree N. 94.406/87, which ensured the exercising of the profession.[6] In analyzing the repercussions observed in the practice of a more interventionist form of working, in comparison with that allied to non-invasive technologies of care, we seek to contribute to the proposal to consolidate the national policy for the humanization of labor and birth.

In this regard, the following objectives were defined: to identify the practices employed by nurse midwives in childbirth care in maternity hospitals of the public health network, and to identify their contribution in the consolidation of the humanization of labor and birth.

LITERATURE REVIEW

The care provided to women during birth has undergone numerous changes over time, resulting from the institutionalization of birth and from technological advances in the field of medicine.[5,7] Although satisfactory in regards to expectations for a fall in maternal and neonatal mortality, the advances in the field of technocracy contributed to women having their bodies defined by a domination which is characteristic of the male gender.[8]

In the past, births were prioritarily assisted in the home environment, by midwives or by women who had affinity with and the trust of the pregnant woman. The assistance to the parturient woman was considered a female matter, involving emotional bonds, beliefs, talismans and prayers; a women's matter. Until the 12th century, male participation was considered to be contrary to the cultural patterns of the time.[9,10]

Little by little, the male figure began to arise in the scenario of birth, and had, as a consequence, the intervention to the detriment and discrediting of the skills of the traditional midwife.[10] This insertion culminated with the adoption of the medicalized technocratic model and the institutionalization of birth, placing the woman in the position of patient, without autonomy over her body, separating her from family members and from her child, upon its birth. Birth came to be seen as a pathological process, of a mechanical character, requiring interventions and incorporating ever more medicalized procedures and techniques.[10]

Currently, the position occupied by Brazil, as one of the countries with the highest rates of cesareans and interventions in the birth, is a reflection of this process of medicalization of women's bodies, which continues to occur even today. Even in 2002, the movement for the humanization of birth in Brazil indicated that the adoption of strict protocols for conducts for attendance had led to the overvaluing of technology and to the banalization of the interventions, as in the case of the cesarean section, which is often undertaken for the convenience of hospitals, medical teams and even of the woman, who becomes submissive in relation to decision-making issues related to her body.[11]

The current medicalization of birth, which seems to be a corroborating data of the high levels of maternal mortality, led the Brazilian Ministry of Health to adopt measures in an attempt to improve these indicators; the active participation of the nurse midwives in care for labor and birth was one of these. In 2015, Brazil presented 62 cases of maternal death

per 100,000 births; in the State of Rio de Janeiro, 566 deaths were notified in 2015, of which 140 occurred in the Municipality of Rio de Janeiro.[12,13]

The mean percentage of cesareans undertaken per year in Brazil is 46.6%; in the private network, this rate can reach 85%. In the State of Rio de Janeiro in 2015, the percentage of cesareans reached 58.41%, while in the Municipality, in the same year, it was 23.41%. The rates continue to be far above the 15% recommended by the WHO, in spite of its reduction through the implantation of the Stork Network in 2011. It is emphasized that in the implantation of the Stork Network, the participation of the nurse midwives was significant in many maternity hospitals which until then did not have any of these professionals.[14]

The high rate of cesareans is not observed only in Brazil. In 2014, the rate of cesarean sections in Europe was from 20% to 22%, while in the United States it was 32.2%. This data reinforces that although Brazil is considered the world leader in cesareans, the world continues to be far from the goal established by the United Nations (UN) and reinforces that the need for humanized care practices in labor and birth is strictly necessary.[15,16]

In this perspective, childbirth must be seen as a physiological, natural and female process - and the professional who works with the pregnant woman must offer means such that she may become the protagonist of this event, ensuring the creation of family bonds and a transition with good physical and emotional qualities to the baby.[2,9] In this context, the participation of the nurse midwife becomes fundamental, and the number of hospitals which opt to include this professional grows, as the principal reference for humanized and embracing care.[9]

The World Health Organization considers nurse midwives to be the professionals who are most appropriate for attention to normal pregnancies and births because they possess less interventionist characteristics in their care.[2]

On 25 May 1998, the Ministry of Health (MS) signed the Ministerial Ordinance N. 2,815, which considered the attention to labor and birth by the nurse midwife to be of the highest importance, as a strategy for reducing interventions, in the attempt to promote safety and respect for the process.[2,3]

The humanization of care for childbirth entails, as a priority, that the work of the professionals should respect the aspects of its physiology, recognize social and cultural aspects of the family, and offer emotional support facilitating a bond between mother and baby. The assistance provided by the nurse midwife permeates a variety of knowledges and skills which directly influence the care for women during labor.[17] In this context, in spite of the stipulations of Ministerial Ordinance N. 569, of June 1st 2000, 572/GM, instituting the Humanization of Prenatal and Birth Program, which points to a policy geared towards returning to women the protagonism in their births, the practice does not reveal this as a reality, continuing to evidence difficulties experienced by pregnant women in obtaining service which is consistent with what is stipulated.[2,3] We perceive, therefore, that the implantation of care for births by nurse midwives is associated with changes in institutional practices and routines, given that it is characterized as an attitude in favor of the humanization of labor and birth.[18]

Emphasis is placed here on the development and use of noninvasive technologies of obstetric nursing care. These are defined as a set of techniques, procedures and knowledges used by the nurse midwife during her relationship of professional care, which, due to her ecological conception, understands birth as a physiological process, respecting its nature, and the women's physical and psychic integrity.[18]

METHODS

A descriptive, quantitative, transversal study, held in two hospitals/maternity hospitals of the public municipal network of Rio de Janeiro, evaluating the records for 2,914 births attended by nurse midwives, in December 2012 - December 2013.

These two hospitals/maternity hospitals are of large size*, run by the Prefecture, whose basic clientele derives from the SUS. The care model is predominantly medicalized, however, in these two hospitals, the humanized model is being implanted. For this reason, it can be admitted that there is a hybrid model of care, in which humanized practices are frequent and coexist with interventionist actions.

The data were collected using an instrument developed for the study and extracted from the two institutions' Records of Births. For making records and carrying out analysis, a database created using the Epi Info software, version 3.5.1, was used. Data analysis was undertaken through descriptive statistics, organized in accordance with absolute and relative frequency, considering the records made in the record book of births attended by the nurse midwives. Data which were not provided, related to each variable, were considered as losses of information and were not used for analysis.

The following variables were analyzed: occurrence of episiotomy, use of noninvasive technologies of care, the position adopted in labor and the Apgar score, as these were considered to be indicators of the reduction of unnecessary interventions and of medicalization in the care. The decision to include the Apgar score as a variable was owed to the fact that this is an important indicator of the vitality of the newborn and, as a consequence, of the impact upon this of the practices employed in the care in the birth.

Complying with the recommendations of Resolution N. 196/96, of 10th October 1996, of the National Health Council, the project was submitted for consideration by, and was approved by, the Research Ethics Committee of the Municipal Health Department, under protocol N. 189/09.

RESULTS

The results were divided between the hospital/maternity hospitals. A total of 3,197 births took place, in Hospital/Maternity A, between December 2012 and December 2013. Of these, 2,190

(68.50%) were attended by nurse midwives. In Hospital/Maternity Hospital B, in the same period, there was a total of 1,681 births, of which 724 (43.07%) were attended by nurse midwives, as shown in Table 1.

In relation to the position adopted by the woman during labor, it was ascertained that, in the two hospitals/maternity hospitals the horizontal lithotomy position occurred in only 109 (3.74%) births. In these births, there was the predominance of the vertical positions, in 1,909 (65.51%); semi-vertical, in 464 (15.94%); lateral in 275 (9.43%), squatting in 86 (2.95%) and on all fours in 22 (0.75%). Other positions corresponded to 49 (1.68%) births. (Table 2).

Regarding the use of noninvasive technologies of nursing care, it was ascertained that the parturient women had freedom of movement, walking around freely (1,616 = 55.48%) or undertaking pelvic movements (573 = 19.67%). Some other instruments were also used, such as the Physioball, in 320 (10.98%) births, and the birthing stool, in 321 (11.02%) births, in order to encourage the adoption of verticalized positions and free pelvic movement.

In order to allow comfort and pain relief, massages were used (1,014 = 34.80%) and luke-warm water through showering (684 = 23.48%). In some births, aromas were used - 535 (18.37%), as shown in Table 3.

Episiotomies took place in only 3.12% of the births assisted by the nurse midwives in Hospital/Maternity Hospital A and in 2.12% in Hospital/Maternity Hospital B, totaling only 148 (5.24%), a percentage far below that classified as tolerable by the WHO, which corresponds to 10%. (Table 4).

The evaluation of the Apgar score indicated that 97.53% of the newborns whose births were assisted by nurse midwives had an Apgar score greater than 7 in the 5th minute of life, considered as good vitality at birth. (Table 5).

Table 1. The proportion of births attended by nurse midwives, in relation to the total number of births in the units. Hospital/Maternity Hospital A and Hospital/Maternity Hospital B, Rio de Janeiro, 2012-2013

Births with nurse midwives vs. total number of births in the institutions	Hosp/Mater. A		Hosp/Mater. B		Total	
	n	%	n	%	n	%
Total number of births	3,197	100.0	1.681	100.0	-	-
	-	65.54	-	34.46	4.878	100.0
Total number of births with nurse midwives	2,190	68.50	724	43.07		
	-	75.15	-	24.85	2.914	100.0

Table 2. Positions adopted by the parturient women in births assisted by nurse midwives. Hospital/Maternity Hospital A and Hospital/Maternity Hospital B, Rio de Janeiro, 2012-2013

Positions adopted during lat the moment of delivery	Hosp/Mater. A		Hosp/Mater. B		Total	
	n	%	n	%	n	%
Vertical	1,596	72.87	313	43.23	1,909	-
	-	54.97	-	10.74	-	65.51
Semivertical	223	10.18	241	33.28	464	-
	-	7.65	-	8.27	-	15.94
Lateral	207	9.45	68	9.39	275	-
	-	7.10	-	2.33	-	9.43
Horizontal	75	3.42	34	4.69	109	-
	-	2.57	-	1.17	-	3.74
Squatting	44	2.00	42	5.80	86	-
	-	1.50	-	1.44	-	2.95
On all fours	8	0.36	14	1.93	22	-
	-	0.27	-	0.48	-	0.75
Others	37	1.68	12	1.65	49	-
	-	1.26	-	0.41	-	1.68
Total	2,190	100.0	724	100.0	-	-
	-	75.15	-	24.85	2,914	100.0

Table 3. Use of noninvasive care technologies in births assisted by nurse midwives. Hospital/Maternity Hospitals A and B, Rio de Janeiro, 2012-2013

Use of noninvasive care technologies*	Hosp/Mater. A (n = 2,190)		Hosp/Mater. B (n = 724)		Total (n = 2,914)	
	n	%	n	%	n	%
Support for positioning						
Encouragement to walk around	1,346	61.48	270	37.29	1,616	55.45
Encouragement to adopt verticalized positions through the use of the birthing stool	191	8.73	130	17.96	321	11.02
Encouragement to adopt verticalized positions through the use of the Physioball	228	10.4	92	12.71	320	10.98
Encouragement of pelvic movements	331	15.12	242	33.43	573	19.67
Support for tactile stimuli						
Use of water through lukewarm showering	410	18.7	274	37.85	684	23.48
Use of relaxing massage	908	41.47	106	14.64	1,014	34.80
Support related to the environment						
Use of ambient music	-	-	82	11.33	82	2.81
Use of aromatherapy	371	16.95	164	22.65	535	18.37
Others	220	10.03	36	4.97	256	8.79

* Each parturient woman used more than one technology during labor.

Table 4. Occurrence of episiotomy in births assisted by nurse midwives. Hospital/Maternity Hospital A and Hospital/Maternity Hospital B, Rio de Janeiro, 2012-2013

Occurrence of episiotomy in births assisted by nurse midwives	Hosp/Mater. A (n = 2,190)		Hosp/Mater. B (n = 724)		Total (n = 2,826)	
	n	%	n	%	n	%
Yes	88	4.0	60	8.29	-	-
	-	3.01	-	2.06	148	5.07
No	2,102	96.0	576	79.56	-	-
	-	72.14	-	19.77	2,678	91.90
Not recorded	-	-	88	12.15	-	-
	-	-	-	3.01	88	3.02
Total	2,190	100.0	724	100.0	-	-
	-	75.15	-	24.85	2,914	100.0

Table 5. Apgar score > 7 at the 5th minute of life, in births assisted by nurse midwives. Hospital/Maternity Hospitals A and B, Rio de Janeiro, 2012-2013

Health Services*	Apgar < 7		Apgar > 7		No record		Total (n = 2,914)	
	n	%	n	%	n	%	n	%
Hosp/Mater. B	11	1.51	706	97.51	7	0.96	724	24.84
Hosp/Mater. A	54	2.47	2,136	97.53	-	-	2,190	75.15
Total	65	2.23	2,842	97.53	7	0.96	2,914	100

* Respecting "n" 724 in Hosp/Mater. B and 2,190 in Hosp/Mater. A.

DISCUSSION

The path of the Brazilian nurse midwife in care to the parturient woman and to normal birth has been long. Its consolidation took place through Law N. 7498/86 and the decree which regulated this, N. 94,406/87, according to which, the incumbency to provide assistance to the parturient woman and to the normal birth falls to this specialist professional.[6] In the mid-1990s, many nurse midwives incorporated obstetric practices recommended by the WHO - and considered adequate by the Ministry of Health - into their practice.[2,3] As a result, the nurse midwife aggregated technical knowledge to humanized and quality care, respecting the ethical precepts and ensuring the woman's privacy and autonomy.[17,18]

One evidence of the insertion of nurse midwives into the care for births in the hospital/maternity hospitals studied was the high percentage of births accompanied by these professionals (68.5% in hospital/maternity hospital A and 43.07% in hospital/maternity hospital B). These data are not yet configured as as high as, for example, the high rate of attendances to normal births by the nurse midwives, in the Normal Birth Center (CPN) of the Sofia Feldman Hospital/Maternity Hospital, in the State of Minas Gerais. There, the total number of normal births was 7,572, since it opened in 2001; and of these, 93.4% (7,072) were assisted by nurse midwives, showing these to be professionals with an active presence and great responsibility for attending births in the institution.[8]

What is observed, however, is that the hospital environment is in constant reconfiguration in the obstetric field, directed towards the perspective of the humanization of birth. In this context, in order to occupy and maintain themselves in the space, the nurse midwives carry out the noninvasive obstetric nursing care technologies (TNICE), which have as their distinctive characteristics the understanding of birth as a physiological process, alongside respect for its nature, and for the women's physical and psychic integrity.[18]

The noninvasive care technologies form part of the humanized model and are widely used, both in reducing length of labor and in relieving pain.[18] Providing an opportunity for the parturient woman to use TNICE was configured as an important strategy in the humanization process of the two institutions analyzed. These TNICE allowed the parturient woman to choose the position which suited her best during labor and birth. It was ascertained in our study that 81.45% of the parturient women chose to give birth in verticalized positions, which they were encouraged to do by the nurse midwives. These positions, considered beneficial for the descent of the fetus, favor the movements of rotation and flexion of the cephalic pole, respecting the physiology, as well as offering the parturient woman greater comfort and autonomy during childbirth.[18]

In addition to this, it was verified that encouragement to walk around was present in 55.45% of the births in the two Hospitals/Maternity Hospitals, reinforcing the idea of choosing the vertical position during the process.

One study which evaluated the intensity of the feeling of pain and behavior during labor and birth, among women who gave birth vaginally, showed that the change to a vertical position during labor is very closely linked to the women's degree of satisfaction, a fact which may be attributed to the reduction in the feeling of pain.[4,18]

A study showed that 50.9% of the total of normal births in the Hospital/Maternity Hospital of Médio-paraíba/Rio de Janeiro, were assisted by nurse midwives, and 49.1% by obstetricians. The study also evidenced that the TNICE were employed in 98.8% of the births accompanied by the nurse midwives, and that those used most were: encouragement to walk around, 70.23%, use of the shower 57.85%, and use of the Physioball.[19]

The adoption of verticalized positions has been indicated as being an important factor in reducing the use of episiotomy,[4] a procedure whose routine use - although it is usually undertaken by obstetricians - has in recent decades been considered unnecessary, according to WHO recommendations.[15] Not undertaking episiotomy, as well as representing a lower risk of posterior perineal trauma, is related to less need for suturing and fewer complications related to healing.[20] Our study ascertained that this procedure did not exceed 5.24%, being, therefore, far below that described as occurring in other countries.[4]

In a similar study, undertaken in Hospitals/Maternity Hospitals of the Municipal Health Network of Rio de Janeiro, the evidence indicated - with a total of 447 (14.2%) births accompanied by nurse midwives in 2008 - that the episiotomy was used in 11.2% of births assisted by these professionals. In contrast, in the births assisted by physicians, the number was five times higher, at 85.8%.[20,21]

We observed that, even inserted in a space considered unfavorable for demedicalization, the nurse midwife works in a less interventionist way, and that her actions favor the protection of the woman's well-being.

It is defined by the WHO (1996) that 70% to 80% of all pregnancies can be considered as of low obstetric risk and that the nurse midwife performs an appropriate and fundamental role for providing care to the pregnancy and the normal birth, assessing the risks and recognizing complications. As a result, the nurse midwife must allow and encourage the exercising of women's citizenship, bringing back the woman's autonomy in birth.[4,10]

The nurse midwife has been the professional who - due to understanding and thinking about birth in a demedicalized perspective and adopting TNICE - dialogues with the woman, shares and seeks a relationship of partnership, respects and strengthens the woman during labor and birth, instrumentalizing her in coping with the physiological pain in labor[2,3,17,18] as well as providing quality care. This dialogue is fundamental for the understanding of the different dimensions involved in the phenomenon of giving birth, such as - for example - the social and cultural dimensions. It is precisely these two dimensions which drive the woman to wish for a natural birth, without interventions, in spite of her seeking hospital care. It is necessary for the health

professional to respect the cultural baggage brought by the pregnant woman, seeking to support her and clarify her fears, doubts and anxieties, without dismissing her beliefs relating to the ways of giving birth.[1,10]

We can perceive, nowadays, that many nurse midwives have incorporated new knowledges, which have been incorporated into their professional *habitus*, generating practices which led them to break with the reproduction of the biomedical model in the obstetric field. In this way they reconfigure their obstetric care practice, centering themselves in encouraging the woman's protagonism and in respect to the physiology of the birth,[3,5] and, in this way, contribute significantly to the consolidation of the policy of humanization of labor and birth.

One of the principal aspects of the policy for humanization of labor and birth is its concern with the repercussions for the newborn. It is known that perinatal asphyxia is one of the main causes of neonatal morbidity and mortality, and that the appropriate care for the parturient woman represents a fundamental role in preventing this.[22] As a result, the evaluation of the vitality of the newborn, through the Apgar score, is configured as an important indicator of the quality of the care received from the nurse midwife in the humanized model. An evaluation which indicates an Apgar score below 7 in the 5th minute of life is considered the most important benchmark in the diagnosis and prognosis of asphyxia.[22]

In the present study, it was ascertained that 97.53% of the newborns received an assessment indicating Apgar scores greater than 7 in the 5th minute of life. Another study evidenced a similar result, in indicating that 99.9% of the newborns whose mothers were assisted in their births by nurse midwives received an Apgar score greater than 7 in the 5th minute of life.[22] These data reiterate the contribution of the nurse midwife to the humanization policy in relation to the prevention of neonatal asphyxia.

We believe that the study presents advances to those previously produced in the area, due to showing current data from two Hospitals/Maternity Hospitals which attend the majority of women in the municipality of Rio de Janeiro, and comparing references to the care for the parturient woman and to the newborn. Emphasis is placed on the fact observed that more and more nurse midwives are adopting the use of TNICE to the detriment of the use of interventionist practices.

The Hospitals/Maternity Hospitals studied are inserted with different purposes in the obstetric field; one is older, and has undergone various transformations, while the other was begun already linked to the proposal for the humanization of birth, encouraged by the Ministry of Health. In one, the nurse midwives are mainly effective employees of the public network, while the other is characterized by the system of contracting professionals through social organizations. In the city of Rio de Janeiro, there are nine hospitals/maternity hospitals linked to the Prefecture's public management. Although the study only addressed two hospitals, we therefore consider these data to be an important contribution.

Nevertheless, we understand that the present study has limits, particularly due to dealing with a scenario in constant transformation, which requires ongoing evaluations. Even so, the consistency of the data analyzed here, in the authors' view, awakens interest and motivation to continue with studies promoting this continuous process of evaluation.

CONCLUSIONS

It is concluded that the practices used most by the nurse midwives were those which did not negatively influence the physiology of the birth, and which are in accordance with what is stipulated by the WHO. Emphasis is placed on encouragement to walk around, to adopt verticalized positions, free movement, and the use of massage or of luke-warm showers.

In spite of their use of noninvasive care technologies, the nurses continue to use interventionist practices, as a reflection of the influence of the medicalized hospital environment where they work. This study demonstrated that the nurse midwives of the institutions studied are in consonance with the stipulations of the Ministry of Health regarding the use of episiotomy, reflected in low percentages. However, when evaluated, this practice's relationship with the parity of the woman revealed there to be a predominance of this intervention in primiparous women, characterizing a remnant of a biomedical model which permeates their care; even so, however, they are within the recommended levels.

The frequent use of noninvasive care technologies led to the conclusion that the nurse midwives are in a process of transformation of the practice towards breaking with the medicalized model and towards work which is less interventionist. As a result, they contribute to achieving the objectives proposed by the WHO for reducing the number of cesareans and interventions in assistance with childbirth, favoring the natural process.

We understand the reflection of the nurse midwife to be essential if the transformation in the hospital scenario of care to childbirth is to remain continuous and to seek new trajectories allied with scientific technical knowledge and humanized care.

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* A large size hospital in Brazil has between 151 and 500 beds.