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VISION OF RECENT MOTHERS ABOUT THE NON-UTILIZATION OF GOOD PRACTICE IN ATTENTION TO CHILDBIRTH[1]

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ABSTRACT
Exploratory-descriptive, qualitative research, derived from a wider project developed in a maternity-school, whose goal was to identify what are the alleged reasons for recent mothers for not using good practices in the labor/childbirth. 310 recent mothers were interviewed from October 2008 to December 2009, of which 26 had no follow-up in labor, 40 in childbirth and 22 post-labor; 156 did not receive food, 62 did not walk around in labor and 27 did not have immediate contact with the newborn. The reports about these practices were organized using the technique of content analysis of Bardin. It was noted that women did not want escort or he was not available; did not receive food, because the professionals not offered or because they had indication of caesarean; they did not walk around not wishing or obstetric indication; and did not have immediate contact with the newborn due to any clinic complication, because they did not want to or professionals did not provided such meeting. It is concluded that the non-utilization of some obstetric practices is related in large part with the professionals attitude, but in some situations the woman decision.

Keywords: Labor. Humanized childirth. Evaluation of health services. Obstetric nursing.

INTRODUCTION

From the decade of 1940s, with the intensification of childbirth institutionalization, this process, which was private and familiar started to be experienced under professionals´ baton of the hospital. The woman is no longer the protagonist, being subjected to standards and apparently safe interventions and, often, without their consent[1].

In 1985, the Conference on Appropriate Technology for Childbirth was held in Fortaleza-CE, Brasil. This meeting resulted in a report named "Letter of Fortaleza", where consist the recommendation of some obstetric practices that must be implemented in order to ensure the safety and well-being of the mother and her newborn (NB), such as freedom of the woman to choose the best position to give birth and the presence of the partner during labor, birth and post-labor. On the other hand, it also recommends the abolition of other techniques considered harmful as the enema, trichotomy, amniotomy, the routine episiotomy and the induction of birth[2].

In Brazil, the obstetric assistance has been characterized by excess of interventions in childbirth, which has contributed to the increase in caesarean rates and the maternal and perinatal morbidity and mortality[1]. In general, the implementation of these interventions is questionable as to the necessity and effectiveness. Concerned about this situation, the World Health Organization (WHO) published in 1996, recommendations for the attention to natural childbirth, distributing them in four categories: A - demonstrated useful practices that should be stimulated; B - clearly harmful or ineffective practices that must be eliminated; C - practices in respect of which there are not enough evidence; and D - practices often used improperly[3].

The evidence available for assistance to the first period of labor indicate that procedures such as fasting, trichotomy and enteroclysis should be avoided, since there is no justification for its use, as well as the active management of labor with

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oxytocin and routine amniotomy. The practices already classified by WHO in the A category, such as walking around, massages and the presence of a partner chosen by the parturient, should be inserted in childbirth assistance[4].

These obstetrical practices have been evaluated in systematic reviews since 1979, when a European Committee was created, which aimed to study interventions to reduce maternal and perinatal morbidity and mortality. The movement for Evidence-Based Medicine (EBM) has an assistive and educational proposal which seeks to fill the gap between research and correct practice, through the search for evidence that supports the conducts and procedures. In perinatal medicine, the first systematic review of randomized clinical trials controlled was published in 1989[5].

The practices recommended by WHO and supported by the scientific evidence, have been generally namely as good practice for childbirth assistance. Even like this, with all the scientific evidence supporting the implementation of these practices in health institutions, some are not used yet[6].

The maternity of the University Hospital of the Federal University of Santa Catarina (HU/UFSC), activated in 1995, has a philosophy that guides the assistance provided since its activation, based on 12 principles, supported on humanization of assistance and interdisciplinary. The institution has established that obstetric and neonatal developed actions must comply the WHO recommendations and the fundamentals of scientific evidence in the area of health[7].

A multidisciplinary group connected to the General Direction of the institution, formed to ensure the implementation of these principles, felt the need to evaluate how they are being applied in assistance practice, from the perspective of the patients. The results of some studies have identified that, generally, the obstetric conducts consistent with the scientific evidence and WHO recommendations have been used during the course of labor, however some users are subjected to food restriction and bed rest, deprived of immediate contact with the NB and without the partner support during labor, childbirth and post-labor[7].

From these results, it arose the concern to identify why some woman in labor of this maternity were deprived of assistance with best practices by scientific evidence during labor and childbirth, i.e. obstetric good practices. Thus, the present study aimed to identify the reasons for non-utilization of good obstetric practices during labor and childbirth, from the perspective of the recent mothers.

This study can contribute to be reviewed some routines and behaviors related to maternity assistance studied and also encourage the reflection of health professionals, from other institutions, which are involved in attention to childbirth and birth to be adopted strategies so that all women can enjoy the benefits of good obstetric practices.

METHOD

It is an exploratory and descriptive study with a qualitative approach, operationalized using a part of data matrix from a wider research project, entitled "The Philosophy of the Maternity HU/UFSC in the vision of the patients, professionals and academics", and whose overall objective was to evaluate the implementation of the philosophy of that maternity, from the perspective of professionals, academics and patients (recent mothers and partners). This macro-project has been developed on the premises of the Maternity of the HU/UFSC, and data were collected from October 2008 to January 2010.

In one of the stages of the macro-project, when it sought to assess the philosophy of motherhood in the vision of the patients (partners and recent mothers), 310 recent mothers were interviewed in joint accommodation in the first 12-24 hours post-labor. The sample size was calculated based on the achievement of 1,600 annual childbirths take place at HU. The satisfaction has been estimated with the care received in 50%, 95% confidence interval and maximum error of 5%[7]. The recent mothers who have had vaginal childbirth or caesarean were included, excluding the submitted ones to elective caesarean or whose fetus or NB were died. The data collection for this stage occurred between October 2008 and December 2009, and went through the interview, in which the recent mothers responded to a questionnaire with open and closed questions.

The open-ended questions allowed the recent mothers to express their opinion about the received attendance, including on assistance aspects related to the implementation of good practices during labor/delivery.

The data selected for analysis in this study are relative to the 310 participants from the macro-project, once all reported that have not undergone at least one good practice during labor/childbirth, i.e. had no partner during labor (26), childbirth (40) and post-labor (22); were subject to restriction of solid or liquids food during labor (156); did not walk around or did not move during labor (62); and did not have immediate contact with the NB (27)[7]. These answers were arranged in analytical categories that allowed the scope of the objective of this research clipping, identifying the reasons for non-utilization of good obstetric practices during labor and childbirth, from the perspective of recent mothers.

To organize the data, content analysis was opted[8], which involves the prioritization of the meanings, leading to a thematic analysis. The operationalization covered pre-analysis, with organization of the material; exploitation of material or encoding; in addition to treatment of the results, inference and interpretation[8]. The interpretation was anchored in the scientific literature related to the knowledge area and the content of public policy relating to the theme addressed in the study. To ensure the anonymity of the participants, in the presentation and discussion of results, the use of flowers names was opted.

The research project that led to this study was approved by the Research Ethics Committee of UFSC, Protocol no 263/07. All aspects involving the survey agreed with the Resolution No. 196/96 of the National Health Council, Brazil. All interviewed signed a Free and Informed Consent Form.

RESULTS AND DISCUSSION

Of the total of recent mothers who participated in the study (310), the median age was 25 years (14-43 years old), most married or in a consensual union (84.9%), white (75.2%) and Catholic (66.4%). About the education, 41.6% had completed elementary school and 37.0%, the high school. With respect to the obstetric characteristics, 51.3% were primipara, and 48.7%, multipara; 70.3% have six or more prenatal consultations; 67.4% had vaginal childbirth and 32.6% were submitted to caesarean[7].

Here will be presented the categories related to the non-utilization of good practices.

CATEGORY 1 - PARTNER ABSENCE ON LABOR, CHILDBIRTH AND POST-LABOR

In this thematic category, the reasons reported by women to not have had partners were diverse. Most of them stated that "*they didn't have time*" to the chosen partner arrive at the maternity before birth. This fact reveals the need that women choose their childbirth partner during pregnancy, and he is responsible for getting her into maternity. If this is not possible, it is essential to contact him as soon as she commits.

> *My husband was gone, as it was a sudden birth* (Camélia).

Others did not have choice, i.e., they preferred to be alone. Despite being considered a beneficial practice, in addition to coat a prerequisite that characterizes the humanized assistance in childbirth[9], the recent mother's desire to be accompanied or not must be protected, as well as the choice of who will be together with her. In order to the rights of citizenship be guaranteed, the recent mother must be respected in its entirety, participating actively in the decisions involving the attendance.

In some situations, the reasons were related to the own partner. For most of them, the chosen partner would not get into the delivery room, for fear or fatigue, although there were also cases in which the partner could not stay in the maternity, because he had to go home and take care of other children.

> *My partner got scared* (Orquídea).

The institutional routine also appears to have interfered a little in initial participation of the partner in the maternity, once that one of the recent mothers participating in the study reported that the husband was guided to bureaucratic

procedures for hospitalization, and, when he returned to the birth center, the childbirth had already occurred. Thus, it is necessary that health professionals working in obstetric admissions are attentive to the stage of labor which the woman is, in order to prevent similar facts, although not frequent, may occur. In addition, hospital institutions must offer appropriate physical space and prepare professionals for the presence of the partner, favoring a better interaction between him and the family of the patient. The unanimous thinking of professionals is important, since the fears and the lack of conviction may interfere negatively in the process of inserting the partner[10], even if the institution adopt the Law of partner and obey it[11-12].

In addition, with respect to the physical space, the Resolution of the Collegiate Board (RCB) 36, published in 2008 predicts that health institutions should have spaces for partners, as a removable chair next to the recent mother, a living room and/or meetings room, in addition to male and female toilets for partners, visitors and families[11].

The findings demonstrate that the institution in which the study was carried out do not curtails the right of women to have a partner, once the reasons were related to recent mother's personal problems and the partner. It can infer that the Law no 11,108 2005, known as "Law of the partner", which impose the health services of the Unified Health System (Sistema Único de Saúde - SUS), of the own or covenant network, to allow the presence of a partner chosen by the recent mother during the entire period of labor, childbirth and immediate post-labor[12], is being respected and fulfilled. It is worth remembering that maternity of HU/UFSC allows and encourages this good obstetric practice since its activation, in 1995.

CATEGORY 2
SOLID OR LIQUID FOOD RESTRICTION IN THE OBSTETRIC CENTER

In this second thematic category, the women's responses were also diverse. Those that were submitted to caesarean or those that had the possibility of being subject to this procedure argued not to have fed or ingested liquid, due to fasting for surgery.

> *I think I was not offered because of the caesarean* (Margarida).
>
> *They didn't know whether it was going to be caesarean or not* (Rosa).
>
> *They explained that if needed to do caesarean, I couldn't be with a full stomach* (Gérbera).

Fasting during labor was recommended for the concern about the risk of aspiration of gastric contents, in case an emergency caesarian with the use of general anesthesia. However, currently, it is known that the use of general anesthesia during labor is very rare[5].

According to the systematic review published in the *Cochrane* Library, there are no sufficient evidence so that fasting is imposed on women in labor, even those with risk of complications[13].

Some of the women reported that they did not know the reason for the restriction of solids or liquids food, other did not receive information from the professionals about the diet, or the only thing they said was that they “couldn't” feed, without offering further explanation about why such a restriction.

> *I think I can't, I don't know* (Violeta).
>
> *They didn't say why* (Girassol).
>
> *I was told that I couldn't eat* (Crisântemo).
>
> *I was told that I couldn't eat; only drink water* (Petúnia).

A study conducted at the University Hospital of the University of São Paulo showed similar results, since many woman in labor did not possess knowledge regarding the restriction of solids or liquids food; they did not understand the reasons for the need of fasting and professionals gave no explanations[6]. Some women have reported that the professionals did not offer or did not want to give the diet when they requested, which shows that there was willingness of women in feeding during the period, but it was curtailed by the professionals.

> *I asked; I don't know why they did not offer* (Flor de Liz).
>
> *They didn't say why. I have just been told that after 7 centimeters of dilation I couldn't take water* (Begônia).

There were also women who don't get fed or ingested liquid, because they had no desire, and yet, some did not do it to avoid vomiting during labor, either through professional orientation or fear that the indisposition occurred.

I didn't want (Azálea).

I was told if I took I could vomit (Glass of Milk).

To avoid not to vomit (Dália).

In another study about the experience and perception of women in labor in relation to food intake during labor, the interviewed who did not want to feed also feared that happened some problem during labor, as sick and vomit, since giving birth earlier, that had occurred[6].

Women who have had a rapid evolution of labor reported that there was no time to feed. In these cases, it has not been offered food still in the birth center.

Everything was very fast and was it already close to the baby born (Camélia).

I had just arrived and already had baby soon (Jasmim).

From the testimonies of a large number of women, it can realize that food restriction is a practice still used, despite the scientific evidence doesn't indicate losses associated with the provision of solid or liquids food during labor for women with low risk of complication. Women should have the autonomy and the freedom to choose if they want or not to eat or drink during labor[13].

The results of this study indicate that some professionals support their practices in the technocratic model of assistance, in which childbirth is seen as a pathological event and may, at any time, require surgical intervention, requiring thus a time of fasting, so there will not be risk of aspiration of gastric contents under a general anesthetic.

CATEGORY 3 - NO WALKING AROUND AND MOVEMENT DURING LABOR

Some women, when questioned about the justifications for not walking and/or moving during the labor, commented that they didn't want to and the pain stopped them, despite having received guidance on the benefits of the practice.

I was in so much pain and I didn't want to move (Lavanda).

I was guided, but I did not used it (Magnólia).

It is known that walking around or any activity that the recent mother performs, it provides the relief of painful perception and speed up the labor. Study on the perception of women about this practice shows that the used felt that it was better to walking around than stay lying down, since the activity helped support and relieve the childbirth pains[6].

In a literature review about demonstrated useful practices, that should be stimulated, as indicated by the WHO[3], the vertical position was used and preferred by women in labor, by enabling the reduction of pain during labor and childbirth, reducing the time of labor and delivery, improving uterine contractility and provide more comfort[14].

In addition to the women who were not walking around or not moved due to pain, there were also those who carried out these practices because having an unfavorable perception regarding the active posture during labor, referring not liking the methods such as the ball and the "seated" position, used to facilitate the movement during this period.

The "seated" position is a little uncomfortable (Perpétua).

I didn't like the ball, I was in a lot of pain and I stayed just a little (Lótus).

The use of the ball and the "seated" position stimulates the vertical position, allows freedom to adopt different positions, allows the exercise of the pelvic rocking, by its characteristic of playful object, brings benefits, in addition to having low financial cost[15]. However the findings of this study show that not all women feel comfortable and want to use such devices. Given this, professionals should respect the decision of the woman and offer other resources.

The indication of caesarean, induction of labor by probe and contraindication for obstetric pathology were reasons reported by women for failing to walking around and made movement during labor. It is known, however, that in certain obstetric situations, it is necessary for the

woman in labor remains at relative or absolute rest.

In some cases, women reported that they "did not have time", because it was committed in or near expulsive period. This hospitalization condition can really make impossible that the woman be oriented walking around or moving, especially in the institutions in which the labor is accompanied in different location than where the childbirth occurs, as in the maternity in study.

The health institutions, which have rooms in PCP System (pre-labor, childbirth and post-labor), in which the woman remains all clinical phases of childbirth in the same environment, enable the woman walking around and change position until the expulsive period. These locations must be developed in a way that meets the advocated actions by RCB n. 36, as the access to non-pharmacological and non-invasive methods of pain relief and the choice of different positions in labor[11,16].

The interviewed said they did not have to walking around, because they already were in labor or with dilation and amniotic sac rupture. These reasons do not justify the non-utilization of this practice. However, the data do not allow to determine if it was the professionals who guided or whether it was due to the own understanding about the experienced process.

> *It was not needed, because it was already in labor* (Gerânio).

> *It was not needed, I came with dilatation and amniotic sac rupture* (Mimosa).

From the results, we note that the reasons for not walking around and movement during labor was not due to the lack of information or stimulation of the professionals who assist the woman, but rather by personal issues, such as the desire to not perform the practice, or the discomfort associated with carrying out the activity.

CATEGORY 4 - ABSENCE OF IMMEDIATE CONTACT WITH THE NEWBORN

When questioned why they did not interact with the baby soon after childbirth, some women responded that the contact only happened after the NB have been evaluated by the professional or after the routine care; others just saw NB, but without touching it. These responses suggest that it was not prioritized immediate skin-to-skin contact with the child, but rather the achievement of care she still in the delivery room.

> *Only after bathing in the recovery room I saw the baby and took him for the first time* (Lírio).

> *First they did the procedure, they only showed [the NB] a little bit* (Narciso).

> *I just saw him, because the room was cold, and they took the child to a heated room* (Brinco-de-Princesa).

The attitude of health professionals in not ensuring skin-to-skin contact shortly after birth has also been observed in another survey conducted in maternity under study. The results showed that, sometimes, the professionals remove the NB to another environment, separating it from the binomial mother-son at the moment that the first interactions between them were being implemented, with the objective of realizing immediate procedures to the baby. This separation may harm the beginning of attachment and forget an essential point to the establishment of their bond[17].

This posture is not understandable, since for the WHO[3] one of the immediate care of NB is the immediate skin-to-skin contact with his mother. Immediately after birth, he should be dry and placed over the abdomen or in the arms of the mother. This contact may cause the intense fall of the temperature of the baby, especially in the delivery cold rooms. Moreover, the NB comes in contact with the mother's skin and avoids to be colonized by bacteria of the health professionals.[3] This first immediate contact is remarkable for the woman, because it is a new and rewarding experience that influence positively on the trajectory and the success of breastfeeding[18].

Other reasons for preventing early contact were the complications with the NB at birth, hospitalization in Neonatal Intensive Care Unit, or even the maternal complications in childbirth. In these situations, the preservation of the welfare of the neonate and the mother is a priority and often requires the immediate separation of them.

> *He was premature and had the cord wrapped around his neck* (Cravo).

He was born well purple and was tangled up in the cordon (Açucena).

I had post-labor complication (Lisianto).

I didn't want to stay with the baby, I was too tired (Gerânio).

The baby didn't stay with me as soon as he was born because I didn't want to (Lótus).

The maternal option not having early contact with the NB was also one of the reported reasons. Thus, despite all the positive effects of this practice singled out by scientific evidence being in breastfeeding duration, in maintaining temperature of the NB, on their blood glucose, or in reducing the crying[19], it must be respected the choice of the woman after the provision of the information about these benefits.

FINAL CONSIDERATIONS

The non-utilization of good obstetrical practices in attention to the childbirth in a maternity that advocates the implementation of the recommendations of the WHO and of the scientific evidence on childbirth assistance was related to both professional attitudes, as well as the decision of the woman and the unavailability of her partner.

The food restriction and deprivation of immediate contact with the NB were directly linked with the professional attitude, since in both cases the health professionals do not favor adoption of these best practices, motivated by the view of childbirth as a high-risk event, which could require a surgical intervention or prioritize the achievement of routine care with the NB that could be postponed.

However personal reasons of the own mother, also prevented the implementation of good practices, such as the presence of the partner and the movement and walking around during labor. The unavailability of the partner and the desire not to have him present were the main justifications presented by women. Many of them also did not walk around and did not move during labor by the mere fact of not wishing it or don't feel comfortable.

The findings of this research allow concluding that some good practices are not yet used in maternity under study. The constraint of solid or liquid foods and the restriction of immediate contact with the NB are inappropriate practices, which must be reviewed and reconsidered by the professional team, since they are not congruent with the philosophical principles that guide the assistance provided in the maternity and with the current scientific evidence. Moreover, they reaffirm the need for the decision of the woman on the non-adoption of some good practices should be respected by health professionals, since they do not interfere negatively on the welfare of the mother, the fetus and NB.

VISÃO DE PUÉRPERAS SOBRE A NÃO UTILIZAÇÃO DAS BOAS PRÁTICAS NA ATENÇÃO AO PARTO

RESUMO

Pesquisa exploratório-descritiva, qualitativa, derivada de um projeto mais amplo desenvolvido em uma maternidade-escola, cujo objetivo foi identificar quais são os motivos alegados pelas puérperas para a não utilização de boas práticas no trabalho de parto/parto. Foram entrevistadas 310 puérperas de outubro de 2008 a dezembro de 2009, das quais 26 não tiveram acompanhante no trabalho de parto, 40 no parto e 22 no pós-parto; 156 não receberam alimentação, 62 não deambularam no trabalho de parto e 27 não tiveram contato imediato com o recém-nascido. Os relatos acerca dessas práticas foram organizados utilizando-se a técnica de análise de conteúdo de Bardin. Constatou-se que as mulheres ou não quiseram acompanhante ou ele não estava disponível; não receberam alimentação, porque os profissionais não ofereceram ou porque tinham indicação de cesariana; não deambularam por não desejarem ou por indicação obstétrica; e não tiveram contato imediato com o recém-nascido devido a alguma intercorrência clínica, porque não quiseram ou os profissionais não propiciaram tal encontro. Conclui-se que a não utilização de algumas das boas práticas obstétricas está relacionada em grande parte com a atitude dos profissionais, mas em algumas situações a decisão da mulher.

Palavras-chave: Trabalho de parto. Parto humanizado. Avaliação de serviços de saúde. Enfermagem obstétrica.

VISIÓN DE LAS PARTURIENTAS ACERCA DE LA NO UTILIZACIÓN DE LAS BUENAS PRÁCTICAS EN LA ATENCIÓN AL PARTO

RESUMEN

Investigación exploratoria-descriptiva, cualitativa, derivada de un proyecto más amplio desarrollado en una maternidad-escuela, cuyo objetivo fue identificar cuáles son los motivos alegados por las puérperas para la no utilización de las buenas prácticas en el trabajo de parto/parto. Fueron entrevistadas 310 puérperas de octubre de 2008 a diciembre de 2009, de las cuales 26 no tuvieron acompañante en el trabajo de parto, 40 en el parto y 22 en el postparto; 156 no recibieron alimentación, 62 no deambularon en el trabajo de parto y 27 no tuvieron contacto inmediato con el recién nacido. Los relatos sobre estas prácticas fueron organizados utilizándose la técnica de análisis de contenido de Bardin. Se constató que las mujeres o no quisieron acompañante o él no estaba disponible; no recibieron alimentación, porque los profesionales no ofrecieron o porque tenían indicación de cesárea; no deambularon por no desearlo o por indicación obstétrica; y no tuvieron contacto inmediato con el recién nacido debido a algún inconveniente clínico, porque no quisieron o porque los profesionales no proporcionaron tal encuentro. Se concluye que la no utilización de algunas de las buenas prácticas obstétricas está relacionada en gran parte con la actitud de los profesionales, pero en algunas situaciones con la decisión de la mujer.

Palabras clave: Trabajo de parto. Parto humanizado. Evaluación de servicios de salud. Enfermería obstétrica.

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