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ORIGINAL ARTICLE

OBSTETRIC CARE IN PUBLIC MATERNITY HOSPITALS: COMPARATIVE ANALYSIS OF TWO COHORT STUDIES

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ABSTRACT

Objective: to compare care during labor and birth in two cohortstudies of a public maternity hospital according to the recommendations of the World Health Organization. **Method**: this is a quantitative cross-sectional study nested in two cohortstudies, 2013 and 2017. The data collection was from medical records and interviews with mothers. Statistical analysis was performed using the Chi-square test of association, with a significance level of 5% and, to verify possible associations (p≤0.05) and logistic regression was performed in the results with p<0.020. **Results**: In this study, 662 women participated, 432 in 2013 and 230 in 2017. Only 15.2% of women had visited the maternity ward before delivery and, in 2017, it increased to 27% (OR=2.041 95%CI 1.379-3.020). The preference for vaginal delivery increased by 1.6%, being, in 2013, 78.8% and, in 2017, 80.4%. The offer of relaxing baths increased by 0.5% in 2017 (63%), of these parturient women, 66.2% progressed to normal delivery. The use of oxytocin to induce labor decreased by 2.9% (2017). The presence of a companion increased in 2017 (91.8%) (odds ratio= 1.861 95%CI 1.083-3.197) (p=0.014). **Conclusion**: in 2017, the recommendations of the World Health Organization were more used than in 2013. Despite this, they still did not meet all the widely recommended practices.

Keywords: Humanizing delivery. Labor. Obstetric. Women'shealth. Humanization of assistance.

INTRODUCTION

Women's health in Brazil has occupied a relevant space in health policies, programs, and strategies, with priorities for delivery and birth care, a focus on overcoming the biomedical model that is still in force and improving the quality of obstetric care, aiming for an integrated system, regionalized and with timely access to women[1].

In 1996, the World Health Organization (WHO) published a classification of common practices in natural birth care, based on scientific evidence, becoming a milestone in promoting healthy birth and combating maternal and neonatal morbidity and mortality rates[2].

The categories proposed by WHO are: Category A - Practices that are proven to be useful that should be encouraged - also called good practices; Category B - Harmful practices that should be eliminated; Category C - Practices that do not have sufficient evidence to support an accurate recommendation and that should be used with caution until further research clarifies the issue; and Category D - Practices frequently used inappropriately[2].

With the advancement of technology, the obstetric practice has changed, generating an improvement in the indicators of maternal and perinatal morbidity and mortality throughout the world. However, the rates of interventions in women and newborns are rising. The excess of interventions fails to consider emotional and human aspects, forgetting that birth care goes beyond the process of getting sick and dying[3]. Due to the new scenario, the World Health Organization published new recommendations related to laborin 2018[4].

The current WHO recommendations set out a set of practices that enhance the quality of care, make childbirth safe, and provide a positive experience for women. Therefore, by promoting a new model of childbirth care according to the local reality, the recommendations contribute to reducing costs and unnecessary interventions during labor and birth[5].

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Despite extensive strategies and programs being instituted in recent years, Brazil remains the protagonist of a model of care in labor, delivery, and birth characterized by the excessive use of obstetric and neonatal interventions. These actions result in unfavorable maternal and perinatal events[6-7].

A national population-based study found that the main reason for the preference for cesarean in the country is still the fear of pain during childbirth, as well as 15% of women did not have the presence of a companion during childbirth, with a predominance of the lithotomy position, 14% underwent episiotomy and in 1/6 the Kristeller maneuver was used during the expulsive period[6].

Corroborating these findings, a cross-sectional study carried out at a university hospital in the capital of the state of Mato Grosso, which serves exclusively through the Unified Health System (*Sistema Único de Saúde* -SUS), found a high rate of cesarean section (51.5%) in recent years and its progressive growth, revealing the intensity of the problem in the performance/repetition of elective cesarean[8].

Therefore, the question is: which recommended and non-recommended practices have been applied over the years in assisting women during labor, delivery, and birth? To answer this question, this study aimed to compare assistance during labor, delivery, and birth in two cohortstudiesof a public maternity hospital according to the recommendations of the World Health Organization.

METHOD

This is a quantitative cross-sectional study nested in two cohortstudies, carried out in 2013 and 2017, in a reference maternity hospital for regular and intermediate-risk births, in a large municipality in the state of Paraná-Brazil, accredited to the *Iniciativa Hospital Amigo da Criança*(IHAC) and the *Rede Mãe Paranaense* (RMP), which exclusively assists the Unified Health System (SUS), offers internships at the technical level, undergraduate and graduate levels of teaching intuitions, consisting of three natural delivery rooms and two cesarean rooms, eight pre-delivery beds, five for newborns and thirty-four puerperium beds in a rooming-in system.

The 2017 data come from a multicentric survey carried out in three health regional offices in Paraná. For this study, only data referring to maternity hospitals at usual and intermediate risk of the 17th Health Region were analyzed, corresponding to 190 women. As for 2013, 3,415 births occurred in 2012, resulting in a sample of 358 women, to calculate the sample size.

Furthermore, we considered an error margin of 5% and a confidence level of 95%. As this is a follow-up study in which losses may occur throughout the investigation period, an increase was defined. 20% for possible losses, resulting in a sample of 432 women in 2013 and 230 women in 2017.

We included women who delivered at the maternity hospital understudy, who accepted to participate in the research, who lived in the urban area of the city and women with usual or intermediate risk of obstetrics. Women with a high-risk diagnosis were excluded.

Data collection took place from July to October 2013 and from July to December 2017. Data were obtained through physical records, Pregnant Women's Record, and interviews with mothers using a structured form 24 hours after delivery, which began with the daily identification of women in the rooming-in unit.

The variables selected for this study were sociodemographic (age, marital status, education, maternal occupation, family income), obstetrical (previous pregnancy, membranes, amniotic fluid, place of birth, justification for cesarean), and those related to care practices inthe delivery and birth according to the recommendations of the World Health Organization (WHO): Category A - Demonstrably useful practices that should be encouraged (visit to the maternity ward, cervical dilation, uterine dynamics, relaxation bath, companions in prepartum, type of delivery) and Category D - Practices frequently used inappropriately (induction of labor with oxytocin, use of misoprostol, type of membrane rupture, position for delivery, condition of the perineum after vaginal delivery).

Categorical variables were expressed as absolute (n) and relative (%) frequencies and analyzed using the Statistical Package for Social Sciences (SPSS), version 20.0. The chi-square association test was applied for bivariate statistical analysis with a significance level of 5%. To verify possible associations ($p \leq 0.05$) and results with $p < 0.020$, multiple analysis was performed using logistic

regression, with the dependent variables "type of delivery" and "intrapartum complications"; the selected independent variables included sociodemographic and obstetric aspects, conditions of hospitalization for childbirth and conditions of labor, delivery, and birth.

In compliance with the determinations of Resolution 466/12, of the National Health Council, both types of research were approved by the Ethics Committee on Research Involving Human Beings of the State University of Londrina, under the approval protocol CAAEE nº 193525139.9.0000.5231, on 16th of July 2013, and CAAEE NumberCAAE: 67574517.1.1001.5231, on May 9, 2017.

RESULTS

We interviewed 662 women, 432 in 2013 and 230 in 2017. In those years, most of the women interviewed became mothers between 20 and 29 years old, with 68.2% and 71.3%, respectively. Of these, 69.7% underwent vaginal delivery (OR= 0.527 95%CI 0.312-0.889). Part of them had from 8 to 11 years of school, 67.5% in 2013 and 43% in 2017, since in this last year their school level increased to more than 11 years.

We observed that, in 2013, part of the women (39.5%) had an income less than or equal to 1 minimum wage (OR = 4.388 95%CI 2.883-6.681). In 2017, 50.8% received between 1 and 2 salaries. Those with an income of up to 1 salary had a vaginal delivery (34.1%), while those from 1 to 2 had more cesarean sections (37.3%). The number of women with partners in 2013 was 84.9% and, in 2017, 87.8% (Table 1).

Table 1. Sociodemographic profile in public maternity hospitals in 2013 and 2017. Paraná, Brazil, 2019

Sociodemographic profile	Year of delivery				p-value†	OR (CI 95%)§
	2013		2017			
	n	%	N	%		
	432	100	230	100		
Age (years old)						
14 to 19	93	21.5	44	19.1		
20 to 29	295	68.2	164	71.3	0.715	
≥30 years old	44	10.1	22	9.5		
Marital Status ‡						
With partner	368	84.9	202	87.8		
Without partner	64	14.2	27	11.7	0.167	
Education level						
1-3years	2	0.5	15	6.5		
4-7 years	111	25.6	59	25.6		3.684
8-11 years	291	67.5	99	43.0	≤0.001	(0.787-17.240)
≥ years	28	6.5	57	24.7		
Maternal occupation						
Paid	174	40.3	91	39.5	0.488	
Unpaid	258	59.7	139	60.5		
Family income						
≤ 1MW*	171	39.5	47	20.4		
1 a 2 MW	97	22.5	117	50.8	≤0.001	4.388
2 a 3 MW	134	31.0	48	20.8		(2.883-6.681)
≥ 3 MW	30	7.0	18	7.8		

*MW: Minimum wage, †Pearson chi-square, ‡Data reported, §Multiple regression

In both years, some women were hospitalized in the latent phase of labor, 57% in 2013 and 46.2% in 2017 (OR=4.339 95%CI 2.490-7.559), progressing to 81.9% cesarean section (OR = 0.903 95%CI 0.732-1.113). However, of those who had dilation in the active phase (37.7 in 2013 and 35.2% in 2017), 46.3% underwent vaginal delivery (dilation in the transition phase rose from 5.3% (2013) to 18.6% (2017)). In 2013, 60.9% had uterine dynamics present (OR= 2.652 95%CI 1.816-3.873) and, in 2017, it rose to 80.4%. Having present uterine dynamics led 74% to progress to vaginal delivery (OR = 0.399 95%CI 0.282-0.564).

In 2013, 79.2% arrived at the service with an intact membrane (OR= 2.488 95%CI 1.750-3.537) and, in 2017, 60.4%. The ruptured membrane increased by 18.8% when comparing one year to another (20.8% in 2013 and 39.6% in 2017). In both years, most women had clear amniotic fluid, 94.4% in 2013 and 93% in 2017. The presence of clear amniotic fluid contributed to a higher occurrence of normal deliveries (OR= 2.532 95%CI 1.299-4.935) (Table 2).

Table 2. Hospitalization conditions for childbirth in a public maternity hospital, 2013 and 2017. Paraná, Brazil, 2019

Conditions of hospitalization for childbirth	Year of birth				p-value†	OR (CI 95%)§
	2013		2017			
	n	%	n	%		
	432	100.0	230	100.0		
Previous pregnancy						
Primigravida	178	41.2	91	39.5	0.205	
Multigravida	254	58.8	139	60.5		1.070(0.772-1.484)
Visited the Maternity						
Yes	66	15.3	62	27.0	≤0.001	
No	366	84.7	168	73.0		2.041(1.379-3.020)
Cervical Dilation						
Latent 0-3cm	246	57.0	106	46.2		
Active 4-7cm	163	37.7	81	35.2	≤0.001	
Transition 8-10cm	23	5.3	43	18.6		4.339 (2.490-7.559)
Uterine Dynamics						
Present	263	60.9	185	80.4	≤0.001	
Absent	169	39.1	45	19.6		2.652(1.816-3.873)
Membranes						
Integral	342	79.2	139	60.4	≤0.001	
Broken	90	20.8	91	39.6		2.488(1.750-3.537)
Amniotic fluid						
Clear	408	94.4	214	93.0		
Meconium	24	5.6	13	5.7	0.059	
Hematic	0	0	3	1.3		

†Pearson chi-square, §Multiple regression

Of the 197 women who had intrapartum complications, 55.3% were multigravidas, 79.2% did not visit the maternity ward, 63.5% arrived with cervical dilatation in the latent phase (OR= 5.507 95%CI 2.314-13.106), 62.4 % had uterine dynamics present (OR=0.713 95%CI 0.502-1.022), 77.2% intact membrane and 85.3% with clear amniotic fluid (OR=0.119 95%CI 0.055-0.258) (Table 3).

In the table, the latent phase data are 0-3cm, as it was possible to adjust due to the collection nomenclature in the year 2013. According to the WHO 2018 data, the current recommendation is for the latent phase of 0-5cm.

Table 3. Conditions of hospitalization for childbirth according to intrapartum complications in the years 2013 and 2017. Paraná, Brazil, 2019

Conditions of hospitalization for childbirth	Intrapartum Intercurrence				p-value†	OR (CI 95%)§
	Yes		No			
	n	%	n	%		
	197	100.0	464	100.0		
Previous pregnancy ‡						
Primigravida	88	44.7	180	38.8	0.159	
Multigravida	109	55.3	284	61.2		
Visited the Maternity ‡						
Yes	41	20.8	87	18.8	0.548	
No	156	79.2	377	81.2		
Cervical Dilation ‡						
Latent phase 0-3cm	125	63.5	227	48.9	≤0.001	
Active phase 4-7cm	66	33.5	177	38.1		5.507
Transition phase 8-10cm	6	3.0	60	12.9		(2.314-13.106)
Uterine Dynamics ‡						
Present	123	62.4	325	70.0	0.056	0.713
Absent	74	37.6	139	30.0		(0.502-1.022)
Membranes ‡						
Integral	152	77.2	328	70.7	0.088	
Broken	45	22.8	136	29.3		
Amniotic fluid ‡						
Clear	168	85.3	453	97.3	≤0.001	
Meconium	28	14.2	9	1.9		0.119
Hematic	1	0.5	2	0.4		(0.055-0.258)

†Pearson chi-square, ‡Data reported, §Multiple regression

The use of relaxing baths increased by 0.5% in 2017 (63%) when compared to 2013, and of these parturient women, 66.2% evolved to normal delivery. The use of oxytocin for inducing labor decreased by 2.9% when compared 2013 with 2017. There was an increase in the use of misoprostol by 3.8% in 2017 (OR= 0.525 95%CI 0.296-0.932). In 2013, 85.6% remained with a companion and, in 2017, it increased to 91.8% (OR= 1.861 95%CI 1.083-3.197) (p=0.014).

In both years, the parturient women presented spontaneous membrane rupture and, in 2017, the artificial rupture decreased to 4.9%. However, during hospitalization, it increased by 9.3% (OR= 0.455 95%CI 0.270-0.767). The preference for vaginal delivery increased by 1.6%. In 2013, it was 78.8% and, in 2017, 80.4%. The type of delivery that prevailed in both years was a vaginal delivery, but spontaneous normal deliveries decreased from 72.4% to 58.3%, respectively (OR= 1.919 95%CI 1.363-2.701) (Table 4).

Table 4. Conditions of labor and birth in a public maternity hospital, 2013 and 2017. Paraná, Brazil, 2019

Labor and Birth Conditions	2013		2017		p-value††	OR (CI 95%)§
	N	%	n	%		
	432	100	230	100		
Relaxation bath ‡						
Yes	268	62.5	145	63	0.462	
No	162	37.5	85	37		
PT induction with oxytocin						
Yes	174	40.3	86	37.4	0.261	
No	258	59.7	144	62.6		
Misoprostol use						
Yes	26	7	25	10.8	0.02	0.525
No	406	93	205	89.2		(0.296-0.932)
Had a companion in the pre-delivery period						
Yes	370	85.6	211	91.8	0.014	1.861
No	62	14.4	19	8.2		(1.083-3.197)
Type of rupture of membrane						
Spontaneous	246	57	123	54	0.07	0.455
Artificial	145	33.5	66	28.6		(0.270-0.767)
Membrane broken during hospitalization	41	9.5	41	17.8		
Type of delivery						
Spontaneous Normal Delivery	313	72.4	134	58.3	≤0.001	1.919
Normal Instrumental Childbirth	7	1.6	4	1.7		(1.363-2.701)
Cesarean	112	26	92	40		
Perineal conditions after vaginal delivery*						
Intact perineum	152	47.6	60	43.5	0.712	
Laceration	127	39.6	60	43.5		
Episiotomy	41	12.8	18	13		
Place of Birth						
Hospital Bed/Bed	165	38.2	12	5.6	0.191	
Birth room	155	35.8	126	54.4		
Surgery Center	112	26	92	40		
Position for delivery						
Lithotomics	318	73.6	132	57.4	≤0.001	7.227
Non-lithotomy back	112	25.9	92	40		(1.440-36.270)
Vertical	2	0.5	6	2.6		
Justification of Cesarean†						
Fetal problems	51	43.5	23	25	0.004	3.285
Progression dystocia	27	24.1	40	43.5		(1.642-6.571)
Iteractivity	26	23.2	18	19.6		
Maternal grievance	8	7.1	11	12		
Total	430	100%	230	100%		

*Data only for vaginal delivery, †Data only for cesarean delivery,††Pearson chi-square, ‡Data reported, §Multiple regression

Complications were higher in cesarean deliveries (60.4%), while in spontaneous vaginal delivery this number was 38% (OR= 0.145 95%CI 0.100-0.210). Instrumental normal delivery presented 2% of complications (OR=6.902 95%CI 4.764-9.998). In 2013, 47.36% of women had intact perineum and 39.6% had lacerated ones. In 2017, intact perineum decreased to 43.5%, equaling, in the same year, with lacerated perineum.

In 2013, 38.2% of births took place in bed and, in 2017, they decreased to 5.6%. The number of births that took place within the delivery room was

35.8% in 2013, increasing to 54.4% in 2017. The number of births that took place within the operating room increased from 26% in 2013 to 40% in 2017. Regarding the position, the lithotomy was maintained. In 2013, it was 70.7% and, in 2017, 57.4% (OR= 7.227 95%CI 1.440-36.270) (p= ≤0.001).

Almost 61% of the complications occurred in deliveries performed in the non-lithotomy dorsal position (OR=0.148 95%CI 0.102-0.214). There was a reduction in Apgar in the 5th min, in 2013, of 99.1% and, in 2017, of 63.9%. Almost all deliveries were performed by physicians and/or medical residents. The most used justification for cesarean section in 2013 was fetal problems (43.5%), while in 2017, progression dystocia (43.5%) (OR=3.285 95%CI 1.642-6.571). The justification of maternal problems increased from 7.1% in 2013 to 12% in 2017 (Table 5).

Table 5. Labor and birth conditions according to intrapartum complications in 2013 and 2017. Paraná, Brazil, 2019

Labor and Birth Conditions	Intrapartum complications				p-value††	OR (IC 95%)§
	Sim		Não			
	n	%	n	%		
	197	100	464	100		
Relaxation bath ‡						
Yes	115	58.7	297	64.1	0.185	
No	81	41.3	166	35.9		
PT induction with oxytocin ‡						
Yes	92	46.7	167	36	0.01	
No	105	53.3	297	64		
Misoprostol use ‡						
Yes	20	10.2	31	6.7	0.126	
No	177	89.8	433	93.3		
Had a companion in the pre-delivery period ‡						
Yes	176	89.3	404	87.1	0.415	
No	21	10.7	60	12.9		
Type of rupture of membrane ‡						
Spontaneous	106	53.8	263	56.7	0.475	
Artificial	69	35	141	30.4		
Membrane Brojen during Hospitalization	22	11.2	60	12.9		
Type of delivery ‡						
Spontaneous Normal Delivery	74	38%	373	80.4	≤0.001	0.145(0.100-0.210)
Normal Instrumental Childbirth	4	2	7	1.5		6.902(4.764-9.998)
Cesarean	119	60.4	84	18.1		
Perineal conditions after vaginal delivery *						
Intact perineum	40	20.3	172	37.1	≤0.001	2.113
Laceration	24	12.2	163	35.1		(1.011-4.416)
Episiotomy	14	7.1	45	9.7		
Place of Birth ‡						
Hospital Bed	37	18.8	141	30.4	≤0.001	0.185
Birth room	41	20.8	239	51.5		(0.117-0.293)
Surgery Center	119	60.4	84	18.1		
Position for delivery ‡						
Lithotomics	78	39.6	372	80.2	≤0.001	0.148
Non-lithotomy back	119	60.4	84	18.1		(0.102-0.214)
Vertical	0	0	8	1.7		
Justification of Cesarean †						
Fetal problems	42	21.3	32	6.9	≤0.001	2.538
Progression dystocia	51	25.9	16	3.4		(1.169-5.506)

*Data only for vaginal delivery, †Data only for cesarean delivery ††Pearson chi-square, ‡Data reported, §Multiple regression

DISCUSSION

Since 1996, the World Health Organization (WHO) has recommended that childbirth be performed with as few interventions as possible[2]. This recommendation was adopted due to poor routine practices, without scientific evidence for its use. Unfortunately, some of these practices remain today.

One of the points discussed is the visit to the maternity ward, an important factor when choosing the mother's labor. In a study carried out in 2018,

regarding the previous visit to the maternity hospital, there was an influence when related to satisfaction with the time of delivery and also to the safety and tranquility of the pregnant woman[9].

Unfortunately, when comparing the cohortstudies in this study, the number of mothers who do not undergo it increased. Another finding in this research was the number of mothers who sought the service even before the water broke, protecting it from artificial breakage. Amniotomy is not a practice for inducing labor recommended by the WHO, as despite being a simple procedure, it is not without risks and there is no evidence to prove its effectiveness and safety[2].

In a survey published in 2020, comparing 2013 and 2016, in the state of Santa Catarina, there was an increase of 16.7% for the practice of amniotomy, which contradicts this study since in the same period studied, the number of artificial membrane ruptures in this hospital in the state of Paraná decreased by 4.9%[10].

Among the "Provenly useful practices and that should be encouraged", the recommendation of a partner of choice for the woman during labor is maintained. The presence of the companion of their choice conveys security, confidence, and tranquility to the woman[11]. In both cohortstudies, the number of women with a companion was higher, with an increase in 2017, showing that this recommendation is being implemented.

Another practice that should be encouraged and recommended by the WHO is the use of non-invasive and non-pharmacological methods of pain relief, such as massage and relaxation techniques during labor. In an integrative review carried out in 2018, among the non-pharmacological methods that are most used are obstetric ball, bath, shower, walking, breathing, squatting, and massage[12].

In this study, the most used method for pain relief was the relaxing bath, and part of the women who underwent it progressed to normal delivery. Freedom of position and movement during labor came to be recommended only for low-risk women, with free movement and upright posture, a position that should be chosen by the woman and supported by health professionals[10].

In a study carried out in 2019, it is possible to perceive a relationship between births in the lithotomy position and neonatal complications[13]. There is evidence that in births performed in the presence of a nurse, practices such as episiotomy, use of oxytocin, and births in the lithotomy position are less performed[14].

In a survey carried out in 2017, we found that 81.45% of the parturient women, stimulated by obstetric nurses, chose to deliver in vertical positions[15]. In this research, the use of the lithotomy position and vertical births increased between the years of studies.

Another practice that should be eliminated is the administration of oxytocics to induce labor. The use of synthetic oxytocin remains not recommended[2,3], as routine oxytocin does not have its proven benefits, although, in this study, it continues to be used[15].

About "Practices frequently used inappropriately", the liberal and routine use of episiotomy is highlighted, which remains not recommended for spontaneous vaginal delivery[2,3]. The number of women with intact perineum decreased between the two years in this study and, in 2017, there was an increase in episiotomies even if not recommended, plus lacerations, that is, more than half of the women were injured in labor, either by lacerations or episiotomies.

The increase in mild perineal lacerations as a result of the decrease in the number of episiotomies is justifiable, as they do not lead to any morbidity for the woman, with better results and fewer complications[16]. According to the WHO, episiotomy is indicated in about 10% to 15% of normal births to reduce tissue trauma during vaginal birth, avoid fecal and urinary incontinence, and perineal injuries, but some institutions have made this a routine practice even without scientific evidence[17].

In a study carried out in 2016, with postpartum women who underwent the practice of episiotomy, they reported that this procedure brought consequences such as pain, due to inflammation of the stitches, and problems during sexual intercourse, which can also cause bruises, infections, perineal ruptures, as well as incontinence, fistulas and even death from infections[18].

Furthermore, if parturient women were informed about the benefits and complications of such a procedure, they would probably choose not to perform it[17]. Therefore, it is up to the nursing team to guide, welcome the mother and companion, transmit tranquility and confidence, in addition to providing support and assistance. The presence of a nurse is an important strategy to reduce unnecessary

interventions, promoting safety for women and humanization in labor and birth[19,20].

Regarding intrapartum complications, most women in the study had complications when they were multigravidas. In a study carried out in 2016, we noticed that multigravidas women have a greater tendency to deliver at shorter time intervals, being an important risk factor for complications such as prematurity, neonatal mortality, among others[21].

Regarding fertility in Brazil, in a study carried out in 2018, the number of children among women in the 1960s and 2015 were compared, showing a significant drop in the fertility rate between years[22]. Despite this, in this research, the number of multigravidas women was higher. Another fact that calls attention is that women who had intrapartum complications arrived with cervical dilatation in the latent phase.

The dilation period is divided into two phases. According to the new guidelines of the World Health Organization, the division between phases occurs at 5 centimeters, when the latent phase starts(4). Early admission at this stage should be avoided, as it is a predisposing factor for carrying out interventions[23].

The data were obtained through medical records and direct interviews with the women, providing the opportunity for them to report the assistance received so that it could be more rigorously evaluated. However, obtaining data from the medical records led to a limitation, as it generates a dependence on the professionals' description of the procedure.

Conducting the survey 24 hours after delivery led to another limitation, as the woman was still in the maternity environment and recovering from labor. The results of this research help health professionals to understand how care is being provided to women during labor and what changes still need to occur for them to comply with what is recommended by the World Health Organization.

CONCLUSION

When comparing the 2013 and 2017 cohortstudies, it became clear that improvements occurred over the years, such as the presence of a greater number of companions during labor, use of non-pharmacological methods for pain relief, and an increase in the number of deliveries normal. These recommendations aim to ensure the well-being of the mother and newborn, and that is why they must be followed.

However, despite some guidelines not being recommended by the WHO since 1996, for example, the routine use of oxytocin is still taking place. The practice of episiotomy has decreased over the years. However, it continues to occur. In addition, the number of births performed in the lithotomy position prevails a practice that is not recommended.

ASSISTÊNCIA OBSTÉTRICA EM MATERNIDADE PÚBLICA: ANÁLISE COMPARATIVA DE DUAS COORTES

RESUMO

Objetivo: comparar a assistência ao trabalho de parto e nascimento em duas coortes de uma maternidade pública segundo as recomendações da Organização Mundial da Saúde. **Método:** estudo quantitativo transversal aninhado a duas coortes, 2013 e 2017. Coleta de dados em prontuários e entrevistas com puérperas. Análise estatística,aplicou-se o teste de associação do Qui-quadrado, nível de significância de 5% e, para verificar possíveis associações ($p \leq 0,05$) e nos resultados com $p<0,020$, realizou-se regressão logística. **Resultados:** 662 mulheres participaram do estudo,sendo 432 em 2013 e 230em 2017.Apenas 15,2% das mulheres haviam realizado visita à maternidade antes do parto e, em 2017, passou para 27% (OR=2,041 IC95% 1,379-3,020). A preferência para o parto normal aumentou em 1,6%, sendo, em 2013, 78,8% e, em 2017, 80,4%.A oferta do banho relaxante aumentou 0,5% em 2017 (63%), dessas parturientes, 66,2% evoluíram para parto normal. O uso de ocitocina para indução do trabalho de parto diminuiu 2,9% (2017). A presença do acompanhante aumentou em 2017 (91,8%) (OddsRatio= 1,861 IC95% 1,083-3,197) ($p=0,014$). **Conclusão:** em 2017, observou-se que as recomendações da Organização Mundial da Saúde foram mais utilizadas em comparação ao ano de 2013. Apesar disso, ainda não atenderam à totalidade das práticas amplamente recomendadas.

Palavras-chave: Parto Humanizado. Trabalho de Parto. Saúde da Mulher. Humanização da Assistência.

ATENCIÓN OBSTÉTRICA EN MATERNIDAD PÚBLICA: ANÁLISIS COMPARATIVO DE DOS COHORTES

RESUMEN

Objetivo: comparar la asistencia al trabajo de parto y nacimiento en dos cohortes de una maternidad pública según las recomendaciones de la Organización Mundial de la Salud. **Método**: estudio cuantitativo transversal anidado a dos cohortes, 2013 y 2017. Recolección de datos en registros médicos y entrevistas con puérperas. Análisis estadístico, se aplicó laprueba de asociación del Chi-cuadrado, nivel de significancia del 5% y, para verificar posibles asociaciones (p 0,05) y en los resultados con p<0,020, se realizó regresión logística. **Resultados**: 662 mujeres participaron del estudio, siendo 432 en 2013 y 230 en 2017. Solo el 15,2% de las mujeres había realizado visita a la maternidad antes del parto y, en 2017, pasó a 27% (OR=2,041 IC95% 1,379-3,020). La preferencia por el parto normal aumentó en un 1,6%, siendo, en 2013, 78,8% y, en 2017, 80,4%. La oferta de baño relajante aumentó un 0,5% en 2017 (63%), de estas parturientas, 66,2% evolucionaron hacia el parto normal. El uso de oxitocina para la inducción del trabajo de parto disminuyó un 2,9% (2017). La presencia del acompañante aumentó en 2017 (91,8%) (OddsRatio= 1,861 IC95% 1,083-3,197) (p=0,014). **Conclusión**: en 2017, se observó que las recomendaciones de la Organización Mundial de la Salud fueron más utilizadas en comparación con el año 2013. A pesar de ello, todavía no han tenido en cuenta todas las prácticas ampliamente recomendadas.

Palabras clave: Parto Humanizado. Trabajo de Parto. Salud de la Mujer. Humanización de la Asistencia.

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