

QUALIDADE DA ASSISTÊNCIA OBSTÉTRICA RELACIONADA AO PARTO POR VIA VAGINAL: ESTUDO TRANSVERSAL

QUALITY OF OBSTETRIC ASSISTANCE RELATED TO VAGINAL DELIVERY: A CROSS-SECTIONAL STUDY

CALIDAD DE LA ASISTENCIA OBSTÉTRICA RELACIONADA AL PARTO VIA VAGINAL: ESTUDIO TRANSVERSAL

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RESUMO

Objetivo: Identificar a qualidade da assistência durante o parto normal, segundo escore Bologna. A necessidade de avaliação da qualidade da assistência obstétrica visa atender às recomendações da Organização Mundial da Saúde e às diretrizes nacionais de assistência ao parto normal. **Método:** Trata-se de um estudo descritivo, de abordagem quantitativa, com delineamento transversal, realizado em um hospital. Participaram do estudo 82 puérperas internadas no Alojamento Conjunto. Para a coleta de dados foi adotada a técnica da entrevista semiestruturada e análise de prontuários. Para a análise dos dados foi utilizado o programa SPSS versão 20.0 e realizada a análise estatística pelo escore de Bologna. **Resultados:** As maiores frequências identificadas apresentaram pontuação 3 e 4, caracterizando a qualidade da assistência durante o parto normal do referido hospital como de média qualidade. Baixo índice de resultados iguais a 0 ou 1 que reportam ao esforço institucional em prol da melhora da assistência. **Conclusão:** Apesar dos achados positivos relacionados à garantia do direito ao acompanhante, utilização do partograma e predomínio da prática do contato pele a pele entre a mãe e o recém-nascido, há necessidade de a instituição adotar estratégias que visem a melhora da qualidade assistencial obstétrica.

Descritores: Parto humanizado; Qualidade da assistência à saúde; Enfermagem obstétrica; Saúde da mulher; Recém-nascido.

ABSTRACT

Objective: To identify the quality of care during normal delivery according to Bologna score. The need to assess the quality of obstetric care aims to meet the recommendations of the World Health Organization and the national guidelines for normal childbirth care. **Method:** This is a descriptive, quantitative, cross-sectional study conducted in a hospital. Eighty-two postpartum women admitted in the Rooming-in participated in the study. For the data collection, we adopted the semi-structured interview technique and analysis of medical charts. For the data analysis, the SPSS program version 20.0 was used and the statistical analysis was performed through the Bologna score. **Results:** The highest frequencies presented scores 3 and 4, characterizing the quality of care provided during the normal delivery of the referred hospital as of medium quality. The low index of results equal to 0 or 1 refer to the institutional effort for the care improvement. **Conclusion:** In spite of the positive findings related to the right to the companion, use of the partograph and predominance of the skin-to-skin contact between the mother and the newborn, the institution needs to adopt strategies aimed at improving the obstetric care quality.

Descriptors: Humanized delivery; Health care quality; Obstetric nursing; Women's Health; Newborn.

RESUMEN

Objetivo: Identificar la evaluación de la calidad de la asistencia durante el parto normal según escore Bologna. La necesidad de evaluar la calidad de la asistencia obstétrica tiene por objeto atender las recomendaciones de la Organización Mundial de la Salud y las directrices nacionales de asistencia al parto normal. **Método:** Se trata de un estudio descriptivo, de abordaje cuantitativo, con delineamiento transversal, realizado en un hospital. Participaron del estudio 82 puérperas internadas en el Alojamiento Conjunto. Para la recolección de datos fue adoptada la técnica de la entrevista semiestructurada y análisis de prontuarios. Para el análisis de los datos se utilizó el programa SPSS versión 20.0 y realizado el análisis estadístico por la puntuación de Bolonia. **Resultados:** Las mayores frecuencias identificadas presentaron puntuación 3 y 4, caracterizando la calidad de la asistencia durante el parto normal del referido hospital como de media calidad. Bajo índice de resultados iguales a 0 o 1 que reporta al esfuerzo institucional en favor de la mejora de la asistencia. **Conclusión:** A pesar de los puntos positivos relacionados con la garantía del derecho al acompañante, utilización del partograma y predominio de la práctica del contacto piel a piel entre la madre y el recién nacido, hay necesidad de la institución adoptar estrategias que apunten a la mejora de la calidad asistencial obstétrica.

Descritores: Parto humanizado; Calidad de la atención de salud; Enfermería obstétrica; Salud de la mujer; Recién nacido.

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INTRODUCTION

Gestation and childbirth are moments that trigger profound changes in the lives of women, couples and the family, and that deserve special attention from health professionals. At this point, there is a need for the implementation of humanized care, which involves welcoming and ensuring frank dialogue, free of judgments and prejudices. A warm assistance that involves active listening, enabling the pregnant woman and the partner to express their anxieties, doubts, anxieties, concerns, in order to guarantee resolute and articulated care with other health services, with the objective of ensuring the continuity of the assistance⁽¹⁾.

In 2000, the Brazilian Ministry of Health (MoH) instituted the Prenatal and Birth Humanization Program (PHPN in Portuguese) aiming at the adoption of measures to ensure improvements in prenatal care and quality of care for childbirth, puerperium and neonatal care. The program established the right to dignified and humanized care for the woman, her relatives and the newborn. The program was based on the practical guide on care in normal childbirth developed by the World Health Organization (WHO) in 1996. This guide, based on scientific evidence, encouraged health teams to carry out proven beneficial procedures to women and the baby, avoiding unnecessary interventions⁽²⁾.

An important aspect of humanized actions during the development of childbirth is that they contribute to the quality of obstetric care, thus providing for maternal and child safety and well-being, thus meeting the recommendations of the World Health Organization (WHO)⁽³⁾. Such recommendations establish the need to comply with the goals related to the third Sustainable Development Goals (SDG) to be achieved by 2030 and that aims to implement actions and strategies targeted at ensuring the quality of sexual and reproductive health and reducing the rate of maternal mortality to less than 70 deaths per 100,000 live births, among others⁽⁴⁾.

Thus, it is necessary to evaluate the care process, aiming to verify whether the hospital practices are in agreement with the scientific evidence available, as well as to verify the impact of such practices on the quality of care provided during normal delivery⁽⁵⁾.

In 2000, based on the premise that childbirth is a physiological event in the female body, the WHO proposed, as a strategy to evaluate the quality of obstetric services

performed during normal birth, an indicator called Bologna score. This instrument consists of five measures: presence of a companion during childbirth; presence of partograph; absence of labor stimulation (use of oxytocin, amniotomy, episiotomy, Kristeller's maneuver) or use of instruments (use of forceps and/or vacuum extractor); childbirth in a non-supine position; skin-to-skin contact of the mother with the newborn (recommended 30 minutes in the first hour after birth)⁽⁶⁾.

Another strategy to evaluate the quality of care provided during normal delivery was established through Administrative Rule 353 of February 14, 2017⁽⁷⁾, which approved the National Guidelines for Assistance to Normal Birth. These guidelines aim, as a general objective, to synthesize and systematically evaluate the scientific information made available regarding care practice at delivery and at birth, in order to contribute to the promotion, protection and encouragement of normal birth⁽⁸⁾. In order to fulfill this general objective, some actions and strategies are recommended in normal delivery care, such as reduction of the variability of conducts among professionals in the process of delivery care; reduction of unnecessary interventions; and implementation of evidence-based practices, among others.

Considering that the humanized actions during childbirth care have a significant influence on the quality of childbirth evolution and on the health of mother and newborn, with consequent reduction and optimization of costs and reduction in mortality rates, the development of the present study is of fundamental importance, since it will provide a reflection on the challenges and potential of the implementation of the recommendations established by WHO⁽³⁾, as well as of the National Guidelines for Assistance to Normal Birth⁽⁸⁾, in the clinical practice of obstetric care.

Thus, the objective of the present study was to identify the quality of care during normal delivery according to Bologna score. To meet this objective, the following guiding question was established: What is the quality of care offered by health professionals during normal delivery and what procedures have been performed?

METHOD

This is a descriptive, quantitative and cross-sectional study developed in the Rooming-in sector of the Hospital de Clínicas de Uberlândia, belonging to the Federal University of Uberlândia (HC-UFU), located in the state of Minas Gerais,

Brazil. Data collection occurred between January and June 2017 and involved the participation of puerperal women hospitalized in this sector and who had experienced vaginal delivery.

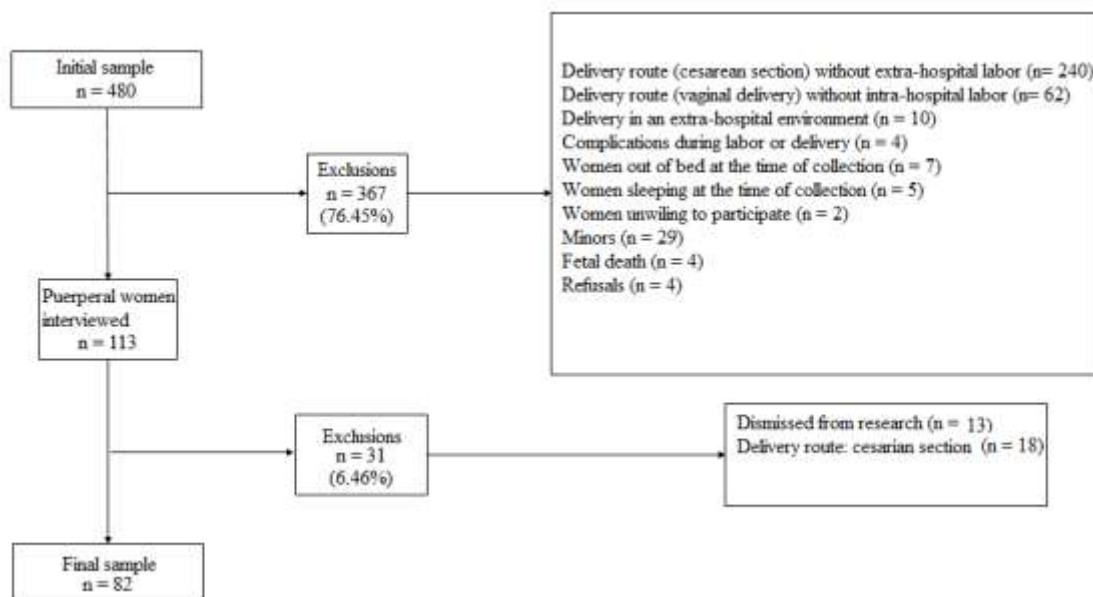
The inclusion criteria were women who aged over 18 years of age, hospitalized in the rooming-in sector of the Unified Health System (SUS), who had experienced labor and vaginal delivery in the hospital environment of the institution where the research took place. Postpartum women who did not meet the inclusion criteria were excluded. In addition, the following exclusion criteria were established: women who, at the time of data collection,

reported unwillingness to participate in the study, who were sleeping or out of bed, who refused to participate in the study, or who had undergone some complications during childbirth and in cases of fetal death.

The sample calculation was performed using G* Power software, version 3.1⁽⁹⁾. The required sample of 82 participants was calculated based on binomial (proportion) exact test, with expected effect size of 0.3, an alpha level of 0.05, and 99% of test power.

Of the 480 women at the beginning of the study, 82 composed the final sample, as described in Figure 1.

Figure 1- Selection process of puerperal women - Uberlândia (MG), Brazil , 2017.



Source: Research data, 2018.

The participants selected to participate in the study were informed individually about the objectives, risks and benefits of the present study, and received the Informed Consent Form (ICF). Data collection was performed by the main investigator of this study, through a semi-structured interview and analysis in medical charts. The data collection took place in a private environment of the rooming-in sector in order to guarantee the privacy and secrecy of the information reported by the puerperal women, as well as to avoid possible biases of research.

The research was submitted to the Research Ethics Committee (CEP) of the Federal University of Uberlândia (UFU), and was approved on 12/6/2016 under the opinion number: 1,864,935. In order to organize the data,

they were double-entered in Microsoft Excel Professional Plus 2016. A data dictionary (codebook) was elaborated with the specification of all the variables addressed in the applied questionnaire and the double-entry (typing) validation technique was used to guarantee fidelity at the time of data transcription⁽¹⁰⁾. After the double-entry validation, a descriptive analysis of the study variables was performed by importing the Excel spreadsheet into the SPSS statistical program, version 20.0.

The variables included in the analyzes were separated into sociodemographic characteristics (age, marital status and schooling) reported by the participants; history of pre-gestational diseases that included the presence of chronic and acute diseases (Acquired

Immunodeficiency Syndrome, diabetes mellitus, arterial hypertension, hypercholesterolemia), which may be related to neonatal mortality, low birth weight, prematurity and the appearance of other obstetric complications⁽¹¹⁾, as collected from hospital charts; obstetric history: parity (number of deliveries to which the woman underwent, categorized as multiparous and primiparous), miscarriage (defined as interruption of gestation up to 22 weeks or fetus weighing less than 500 grams or measuring less than 16 cm, if the gestational period is unknown)⁽¹²⁾ and previous caesarean sections; aspects related to the current gestation, such as its duration (expressed by gestational age based on ultrasonography performed in the first trimester or the date of the last menstrual period, recorded in hospital medical charts), birth route (distinction of the occurrence of vaginal delivery with the use of forceps or not), APGAR scale in the first and fifth minutes of the child's life (assessment scale of the essential physical functions of the neonate in the first minutes after birth, which includes a score of 0 to 2 for the characteristics: heart rate, respiratory effort, muscle tone, reflex irritability, and skin color)⁽¹³⁾, being collected from medical charts.

To evaluate the quality of care during labor and delivery, the Bologna score was considered. This evaluation instrument consists of 5

measures: 1) presence of a companion during childbirth; 2) use of partograph; 3) absence of labor stimulation; 4) delivery in the non-supine position; and 5) skin-to-skin contact between mother and child. Each variable is assigned grade "1", if present, and "0", if absent. The final result is obtained with the sum of the scores of all measures. The maximum score "5" corresponds to the greatest quality of care, and the "0" score corresponds to a poorly conducted delivery. Scores among these limits correspond to variations in the quality of care⁽⁵⁻⁶⁾. Among the stimuli analyzed, we considered amniotomy, episiotomy, the use of stimulant drugs (oxytocin and misoprostol) and the use of forceps during the expulsive period. It should be noted that the lost data were categorized as "unidentified" and did not exceed the accepted rate that is up to 5% of the total data of a database.

RESULTS AND DISCUSSION

The present study had the participation of 82 puerperal women with a mean age of 25.3 years, who were admitted to the emergency room of the Hospital das Clínicas de Uberlândia, Federal University of Uberlândia (HC-UFU) and were assisted during labor and delivery at the obstetric center of the referred hospital. Other sociodemographic characteristics are described in Table 1.

Table 1 – Women's sociodemographic characteristics - Uberlândia (MG), Brazil, 2017.

Characteristic	All postpartum women	
	n (82)	100 (%)
Age		
18-24 years	43	52.4
25-41 years	39	47.6
Marital status		
Single	53	64.6
Married	29	35.4
Schooling		
Complete High School	36	43.9
Incomplete High School	17	20.7
Incomplete Primary Education	9	11
Complete Primary Education	9	11
Incomplete Higher Education	8	9.7
Complete Higher Education	3	3.7

Source: Research data, 2018.

Regarding the history of previous diseases, 81 (98.8%) women did not have diseases before pregnancy and 1 (1.2%) had

hypercholesterolemia. Other characteristics of the obstetric clinical history are described in Table 2.

Table 2 - Women's obstetric history - Uberlândia (MG), Brazil , 2017.

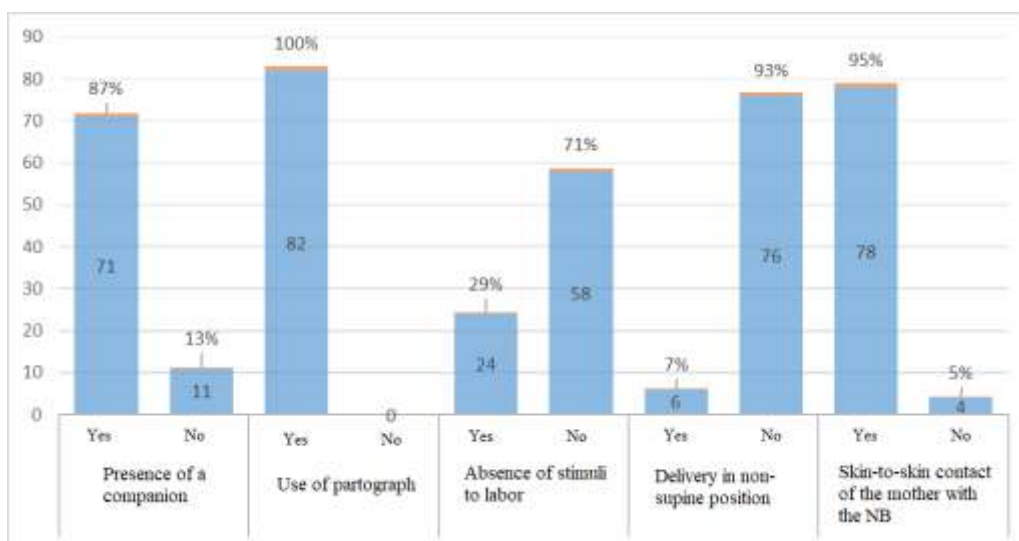
Characteristic	All postpartum women	
	n (82)	100 (%)
Parity		
Multiparous	55	67.1
Primiparous	27	32.9
Previous miscarriage		
No	63	76.8
Yes	19	23.2
Previous Cesarean section		
No	69	84.1
Yes	13	15.9
Duration of gestation		
37-40 weeks	72	87.8
32-36 weeks	6	7.3
41 weeks	3	3.7
Unidentified	1	1.2
Delivery route		
Vaginal without forceps	79	96.3
Vaginal with forceps	3	3.7
APGAR scale at 1st minute of life		
Score from 7 to 10	77	93.9
Unidentified	3	3.7
Score from 0 to 6	2	2.4
APGAR scale at 5th minute of life		
Score from 7 to 10	80	97.6
Unidentified	2	2.4

Source: Research data, 2018.

Care delivery procedures according to the Bologna score are described in Figure 2. It should be emphasized among the stimuli used, the amniotomy 29 (35.4%), the episiotomy 23 (28%), the use of oxytocin 20 (24.4%) and misoprostol 12 (14.6%) and

the use of forceps during the expulsive period 3 (3.6%). Among the family members chosen by the puerperal women to be their companions, the father of the child (52.4%, n = 43) and the mother of the parturient (19.5%, n = 16) stood out.

Figure 2: Bologna Score Quality Standards for deliveries at the Hospital de Clínicas de Uberlândia, (MG), Brazil, 2017.



Source: Research data, 2018.

Regarding the presence of companions during labor and delivery, most of the women in the present study responded positively. In

addition, no cases were reported in which the absence of companions was due to the hospital's refusal to respect this right, provided for in Law

no. 11,108 of 2005, being a good indication of the quality of care of HC-UFU. It is known that the companion chosen by the woman gives her confidence, improves the chances of normal delivery and satisfaction of the woman with childbirth, besides decreasing the use of pharmacological analgesia and risks of complications⁽¹⁴⁾.

The compliance of the HC-UFU hospital in assuring the right to the companion to most of the parturients diverges from what has been found in the literature⁽¹⁴⁻¹⁵⁾. A survey of 160 pregnant women and puerperal women belonging to two philanthropic maternity hospitals in Brazil found that 92 (57.5%) of the participants were unaware of that law and 106 (66.2%) of them did not have the presence of the companion in the whole process of labor⁽¹⁵⁾. Results from the "Nascer no Brasil" (Being Born in Brazil) survey, conducted in 2012, with 266 hospitals and a total of 23,940 puerperae, also identified continuous presence of the companion in only 18.8% of cases, with accompanying peaks before or during admission (70.1%) and when the woman is already in the rooming-in (61.3%). However, the presence of the companion was indicated by 84.5% of the women as an important element for a better and calmer birth⁽¹⁴⁾.

As the companion, the baby's father may have the role of supporting the mother by helping her to undergo contractions and to perform nonpharmacological methods of pain relief or by cutting the umbilical cord. In addition, studies show that paternal participation during the delivery process is considered positive by puerperal women, since it favors the bond between the couple and the newborn⁽¹⁶⁾.

These evidences demonstrate that the participation of the father should be constantly stimulated during the gestation, labor, delivery and puerperium. In addition, several scientific studies have shown that pregnant women who had their partners as companions felt safer and more confident during childbirth⁽¹⁾. This evidences the importance of the health professionals' role in encouraging father's participation throughout the delivery process.

Another indicator of the quality of care is the use of the partograph, observed in all medical charts. The use of the partograph allows the professionals assisting the delivery to identify deviations in the maternal and fetal well-being and in the evolution of the childbirth⁽⁶⁾, as well to identify women who require obstetric

intervention. In addition to the use of the partograph by health professionals involved in parturient care, an important aspect to be evaluated periodically and that influences the quality of care is the level of knowledge of the professionals who complete the partogram. This was performed in a study in Ethiopia and it was found that more than half of the participants presented a good level of knowledge about the partograph. Thus, it was recommended periodic training related to the partogram⁽¹⁷⁾. In the present study, only the use of the partograph was evaluated, being verified the need for new studies that also evaluate the level of knowledge of the health professionals regarding their completion and analysis for directing the clinical conduct.

Regarding the use of stimuli to labor, the WHO recommends that the practice of episiotomy should not exceed 10% of the cases, since it does not prevent the occurrence of more severe perineal laceration, and is related to maternal dissatisfaction and pain in the puerperium. Despite this recommendation, in the present study, the practice of episiotomy reached 28%. In this aspect, there is the need of raising awareness and enhancing training of the health professionals involved in the direct assistance to the childbirth in relation to the need for greater efforts to reach the goal stipulated by the WHO, thus guaranteeing the quality of obstetric care. In addition, puerperal women should be instructed to seek information about episiotomy, since the lack of knowledge about this practice is considered a factor contributing to the routine performance of this procedure⁽¹⁸⁾.

Another aspect that should be banished from routine care practices is the use of uterotonics, which are beneficial only in proven cases of uterine contractility dysfunction, and are related to increased use of forceps, episiotomy, analgesia and emergency cesarean sections⁽⁶⁾. A descriptive and retrospective study carried out in a public maternity hospital in the city of Rio de Janeiro revealed that 56.6% (n = 605) of the patients without episiotomy had first-degree perineal laceration; 38.6% (n = 431) remained with intact perineum and only 4.6% (n = 51) of them suffered second-degree lacerations. These data indicate that genital lesions in vaginal delivery can be prevented through good care since, according to scientific evidence, the routine use of this procedure does not reduce the risk of severe perineal trauma (3rd and 4th degree

lacerations), stress urinary incontinence and dyspareunia, besides being associated with discomfort and perineal pain during the puerperium⁽¹⁹⁾.

The position of labor, also evaluated by the Bologna score, influences the evolution of a child with fewer distorts. In the present study, the occurrence of a non-supine position during childbirth was found in only 7% of cases, that is, a figure that was much lower than expected. This scenario demonstrates the need for the training of health professionals in hospital institutions to guide the parturients about the benefits and the right to adopt other positions during the time of delivery.

It should be noted that any non-supine position that is adopted is associated with decreased duration of the expulsive period and the need for episiotomy. In addition, it facilitates the physiological process of delivery, as it relaxes the pelvis, increases freedom of movement and hip flexibility, which help in the rotation of the fetal presentation, as well as decreased pain sensations⁽¹⁹⁻²⁰⁾.

In addition, the horizontal positioning for childbirth is related to a greater compression of the aorta artery and vena cava, making it difficult to exchange gas between the mother and child binomial and reducing the effectiveness of uterine contractions⁽²¹⁾. However, lithotomy is still the most used position for birth in a hospital environment because it is easier for professionals to monitor contractions through abdominal palpation, to perform vaginal examinations and invasive maneuvers, and to verify the fetus' head position and heart rate⁽²²⁾.

Other evidence demonstrating the benefits of maternal positioning during labor was presented in a study conducted in Italy, which identified that adopting the parturient's chosen position contributed to the reduction of maternal pain, operative vaginal delivery, cesarean surgery and episiotomy rates⁽²²⁾. These findings reflect the importance of the health professionals' role in encouraging maternal protagonism during labor, which includes respecting the woman's choice of the most comfortable position.

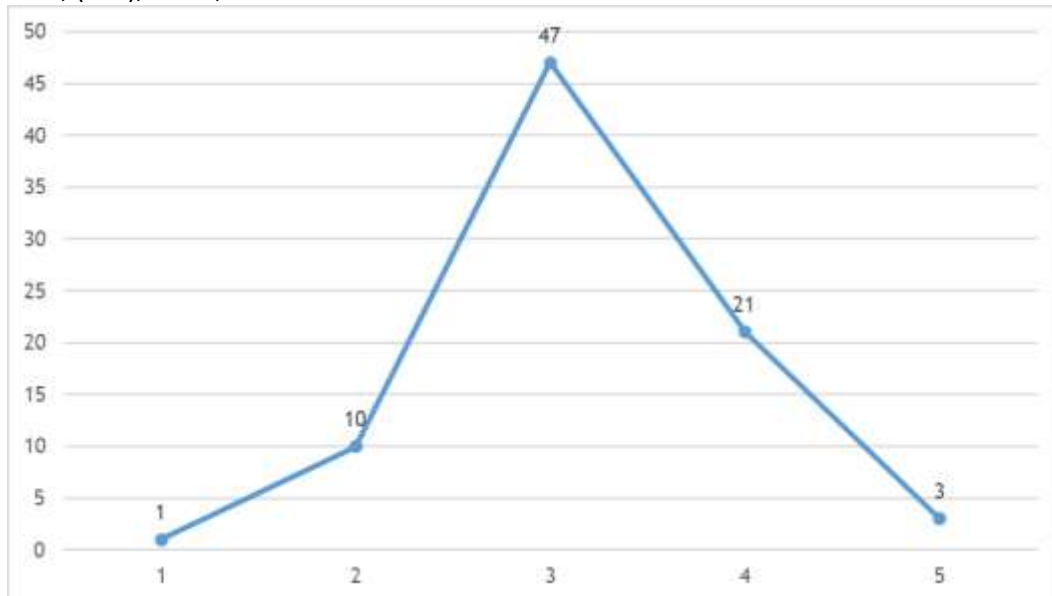
The practice of skin-to-skin contact between the mother and the newborn occurred in 95% of the cases, which is a positive aspect of care provided to the parturients by HC-UFU. This is because in the first minutes of life, infants should be placed close to the mother continuously for at least half an hour in order to promote the baby's recognition and stimulate breastfeeding⁽²³⁾. This contact promotes an increased amount of some hormones that stimulates the creation of the mother-child bond and the let-down reflex. Breastfeeding in the first hour of life, in turn, guarantees the baby's early immunological protection and the supply of food rich in essential nutrients⁽²⁴⁾.

In addition, skin-to-skin contact in the immediate period after birth provides protection and warmth for the newborn who has experienced a decrease in body temperature due to the exit of the maternal uterus into the external environment⁽²⁴⁾. In this context, in order to identify the prevalence of compliance with this practice, a study conducted in the Brazilian Northeast region with 107 puerperal women demonstrated that this practice was compromised when associated with cesarean section⁽²³⁾. Other risk factors identified in a systematic review were: low family income, maternal age under 25 years, low maternal schooling, absence of prenatal consultations, home birth, lack of orientation on breastfeeding in prenatal care, and prematurity⁽²⁵⁾.

Therefore, there is a need to consider such risk factors during care. In addition, another aspect that should be analyzed in later studies is how this skin-to-skin contact has been performed, its duration and its effectiveness on breastfeeding.

The highest frequencies found in this study for the Bologna score were scores 3 and 4, suggesting that HC-UFU obstetric care is of medium quality. However, the low index of results equal to 0 or 1 suggests that the institution has made efforts to adapt to the use of more beneficial delivery practices (Figure 3).

Figure 3 - Bologna score for the attendances performed at the maternity hospital of the Hospital de Clínicas de Uberlândia, (MG), Brazil, 2017.



Source: Research data, 2018.

A study that evaluated three maternity hospitals in Natal, Rio Grande do Norte, with a sample of 314 postpartum women found an average general Bologna score of 2.1; the main type of stimulation in labor was oxytocin (52.9%) and the lowest percentile found were in the non-supine position (0.3%) and in the use of the partograph (2.2%)⁽⁵⁾. Another study carried out in the city of Curitiba-PR, in three SUS institutions, also identified low rates. Maternity A obtained final scores of 1 (78.7%) and 2 (21.3%) for the 80 charts surveyed. On the other hand, in institution B, among the 126 medical charts observed, the final scores 1 (43.7%) and 2 (44.4%) were the most prevalent. The C institution had final scores of 1 (30.5%), 2 (45.5%) and 3 (19%) for the 200 charts analyzed⁽⁶⁾.

In view of the above, it is evident that the main finding of the study was that the hospital offered a good quality of care, with the majority of women having been accompanied during delivery by a person they had chosen, besides the existence of skin-to-skin contact between mother and newborn. However, behaviors such as the adoption of a supine position and the use of some method of labor stimulation were extensively identified. This indicates the need to improve some aspects of care in order to meet the national guidelines for normal delivery care, as well as to help meet the goals of the third SDGs proposed by the WHO.

Among the limitations of the study, we highlight the fact that the sample was

homogeneous. In this sense, we suggest, in future studies, the inclusion of a more heterogeneous sample, considering another type of birth route and the inclusion of supplementary health. This will make it possible to identify the association of these factors with the quality of care, thus contributing to the professional practice in several scenarios.

CONCLUSION

The findings of this study demonstrate that the WHO recommended procedures for delivery and birth, such as skin-to-skin contact lasting more than 30 minutes, non-supine positions for delivery, episiotomy and uterotonics only in cases that are proven to be necessary of these interventions, should be periodically evaluated by hospital managers, since the analysis of care quality by the Bologna score showed aspects that demand improvements.

However, the present institution was able to effectively work some aspects of the humanization of obstetric care, such as the guarantee of the right to accompany companion, use of the partograph for all the participants of the research and the predominance of the practice of skin contact between the mother and the newborn. Such actions should be continuously encouraged by health institutions, aiming at a better quality of obstetrical care and contributing to maternal and neonatal well-being and health, and also to the reduction of costs that

are indirectly related to the non-performance of these practices.

Finally, another strategy is to invest in the training of health professionals who make up the multidisciplinary team of childbirth care, valuing the knowledge of each member in their specialty, and dividing the functions in a more homogeneous way.

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