

Obstetric practices in childbirth care and usual risk birth

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Abstract

Objectives: to analyze the incidence of obstetric practices in labor and childbirth care at usual risk in a tertiary hospital.

Methods: cross-sectional, descriptive study with a quantitative approach. Data were collected from 314 Monitoring Sheets of Labor and Childbirth Care of women who had their birth attended at the institution, from July 2017 to July 2018. The study was approved by the research ethics committee, with the embodied opinion number 2.822.707.

Results: most women in the study were between 20 and 34 years old, coming from the city of Fortaleza, Ceará; had completed high school; and had unpaid work. The prevalence of good practices was identified: umbilical cord clamping in a timely manner (81.5%), immediate skin-to-skin contact (73.9%), breastfeeding in the childbirth room (74.2%), freedom of position and movement (72.3%), completion of the partograph (66.6%), presence of a companion (66.2%), offer of a liquid diet (65%), and non-pharmacological methods for pain relief (54.8%). As for interventional practices, we identified: venoclysis (42.4%), oxytocin infusion (29%), and amniotomy (11.1%).

Conclusions: advances in the adoption of good practices based on scientific evidence are noteworthy; however, the technocratic model of childbirth care for women at normal risk persists.

Key words *Perinatal care, Normal childbirth, Midwifery*



Introduction

Advances in obstetrics have contributed to improving maternal and perinatal morbidity and mortality indicators worldwide. However, they allowed the implementation of a care model that considers pregnancy, childbirth, and birth as pathologies, exposing women and babies to high rates of interventions, which should be rather used cautiously and only in situations of need, and not as routine practices.¹

From the 1980s onwards, a transitional movement in the obstetric care model has been observed. The advent of care based on scientific evidence emerges as one of the most important milestones in the change in the Brazilian obstetric care paradigm.²

Thus, the World Health Organization (WHO) developed the document “Good practices in labor and birth care”, based on scientific evidence. These practices were classified into categories of usefulness, efficacy and risk, encouraging the use of practices that have been proven to be useful instead of harmful and/or ineffective ones, which should be avoided; recommending caution in relation to those practices based on little evidence; and discouraging practices that are inappropriately used.³

In Brazil, with the purpose of reorganizing maternal and child care, the Stork network (*Rede Cegonha*) aims to ensure the right of women to reproductive planning and humanized care during pregnancy, childbirth, and the puerperium, and the right of children to safe birth and healthy growth and development. Thus, it advocates the adoption of health care practices based on scientific evidence described by the WHO.⁴

In this perspective, the National Guidelines for Assistance to Normal Childbirth aims to guide Brazilian women, health professionals and managers on important issues related to the routes of childbirth, their indications, and conduct based on the best scientific evidence available.¹

Recently, WHO published new guidelines to set global standards of care for healthy pregnant women and reduce unnecessary interventions. The adoption of these recommendations aims to provide pregnant women at risk with a positive experience, capable of recognizing that each birth is unique and that the duration of the first stage of the process varies from one woman to another.⁵

However, the reality of many health institutions indicates resistance to these recommendations. The humanization of this assistance to women in the birth process is still a challenge that health services and professionals must take on and conquer.⁶ The

adoption of the humanized model in health institutions implies not only changes in care, but also changes in hospital culture, whose care routines must meet individual needs of women and their families.⁷

Considering the growing search for humanized care and adoption of good practices, the following question was proposed: What practices in labor and childbirth care are prevalent in the care of parturients at usual obstetric risk in a Tertiary Hospital in Fortaleza, Ceará?

The challenge of transforming the labor and birth care model in the Brazilian scenario, following the recommendations of WHO and the Ministry of Health, has contributed to the emergence of several studies and, consequently, to the rise of the theme. Given these findings and the experience in service as a resident in Obstetric Nursing, there is an interest in developing the research in the context of a mother and child reference hospital in the State of Ceará.

In order to contribute to the discussion about the adoption of practices based on scientific evidence, during childbirth and birth, this study aims to analyze the incidence of obstetric practices in the care of mothers at usual risk, in a tertiary hospital in Fortaleza.

Methods

This is a documentary, cross-sectional, descriptive study with a quantitative approach, carried out in a tertiary level hospital located in the city of Fortaleza-Ceará. The institution is a reference in the state in providing highly complex health services in the areas of Gynecology, Obstetrics, Neonatology, Internal Medicine, and Surgery.

Data were collected, during the month of September 2018, through the Monitoring Sheets of Labor and Childbirth Care of women who had their labor and childbirth assisted at the institution, from July 2017 to July 2018.

A structured form was used for document analysis based on information from the institutional form. The selection of variables was based on the document “Good practices in labor and birth care”, in line with the object of study. The variables analyzed were: Category A - Practices demonstrably useful and that should be encouraged (presence of a companion, completion of the partograph, freedom of movement in the position, offer of liquid diet, non-pharmacological methods for pain relief, cord clamping in a timely manner, immediate skin-to-skin contact, breastfeeding in the childbirth room); Category B - Clearly harmful or ineffective practices

that must be eliminated (enema, trichotomy, venoclysis, oxytocin infusion, lithotomy position); Category C - Practices without sufficient evidence to support a clear recommendation and which should be used with caution (amniotomy, Kristeller maneuver); and Category D - Practices frequently used inappropriately (episiotomy).

To calculate the sampling, the number of vaginal deliveries performed during this period was considered, and its size was subsequently defined using a 95% confidence interval, a significance level of 5% (sampling error). After performing the calculations, a sample of 314 sheets was obtained. This study included the sheets of women who had their childbirth vaginally. The sheets of women who do not fit the usual obstetric risk classification, who had miscarriages and stillbirths, who did not have labor and childbirth attended at the hospital, and sheets without the signature of the professional who completed the completion were excluded. The selection of sheets was random (Figure 1).

Statistical data were organized and tabulated in the IBM SPSS Statistics 20 Software, through exploratory analysis of variables and descriptive statistics. The choice of variable (pregnancies) for discussion of the study was based on better understanding and adequacy of analysis regarding the incidence of obstetric practices.

The study was approved by the Research Ethics Committee of the Dr. César Cals General Hospital (HGCC – Portuguese acronym), under opinion number 2.822.707. Care was taken as explained in the Guidelines and Regulatory Norms for Research involving human beings, approved by Resolution 466/12 of the National Health Council (CNS).⁸

Results

Regarding the characterization of the sociodemographic profile of women who had vaginal childbirth at the institution, it was found that most were aged between 20 and 34 years old, came from the city of Fortaleza, had completed high school and did not have a paid job. Regarding obstetric data, the proportion of women who attended prenatal consultations was 98.1%. Regarding parity, 56.4% of the women had already had one or more deliveries (Table 1).

With regard to practices that have been shown to be useful and should be encouraged, 72.3% of women moved during labor. Regarding the companion, 66.2% of the parturients had the presence of a companion of their own choice during childbirth. As for the use of the partograph, 66.6% of

the women had their labor monitored by this instrument. About 65% of women ingested liquid during labor.

As for non-pharmacological methods for pain relief, 54.8% of women used some type of non-pharmacological method during labor. Among them, the most used included massage, pelvic swing, breathing exercises, and pelvic exercises.

Regarding the adoption of good practices in the care for usual-risk births, most newborns were subjected to umbilical cord clamping after stopping the pulsation or between 1 and 3 minutes after birth (81.5%).

As for breastfeeding, 74.2% of babies were breastfed in the childbirth room. Immediate skin-to-skin contact with the baby was made possible for 73.9% of the women (Table 2). As a limitation of the study, it was impossible to measure the duration of such practices, since this information was not included in the institutional form.

With regard to clearly harmful or ineffective practices performed during labor and childbirth, it was found that 42.4% of women underwent peripheral venipuncture (venoclysis), 29% received oxytocin during labor. About 8.9% of the parturients underwent trichotomy (shaving the pubic hair) and 0.3% enema (intestinal lavage). Regarding the birth position assumed at the time of childbirth, 6.7% of the women gave birth in lithotomy position.

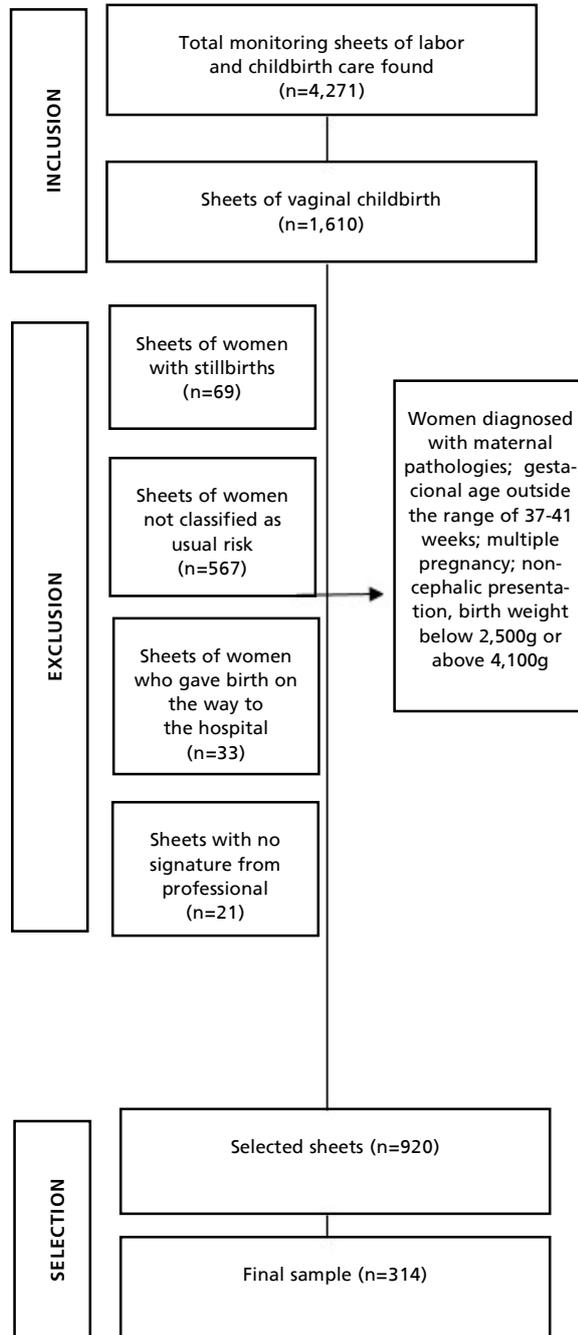
Regarding practices without sufficient evidence to support their recommendation, 11.1% of the parturients underwent amniotomy (artificial rupture of the amniotic sac) and 1.9% underwent Kristeller maneuver (fundal pressure). Regarding the practices frequently used inappropriately, episiotomy was performed in 7% of the women (Table 2).

Regarding the incidence of good practices during labor and childbirth of usual risk in women that experienced pregnancy for the first time, 52.9% had a companion during childbirth and 51.2% used some non-pharmacological method for pain relief during labor (Table 3). However, the practice of episiotomy and Kristeller maneuver were more prevalent in this group, with percentages of 72.7% and 66.7%, respectively (Table 4).

Regarding the prevalence of good practices in women who had already experienced one or more pregnancies, the results showed that 56.9% had the progress of labor monitored by partograph and 54.2% were able to assume freedom of position and movement. Fluid intake during labor was better described in multiparous women (52.4%) (Table 3). As for interventional practices, enema (100%), venoclysis (54.9%), oxytocin infusion (52.8%), and

Figure 1

Flowchart of selection of Monitoring Sheets of Labor and Childbirth Care.



amniotomy (54.3%) were more prevalent in this group. The percentage of trichotomy was equivalent in the two groups (50%) (Table 4).

Discussion

The results of this study sought to analyze the incidence of proven useful practices; harmful and/or ineffective practices that should be avoided; practices that should be recommended with caution in relation to those based on little evidence and that should be discouraged during usual-risk labor and birth care. For the analysis of this study, we sought to use the group of women at habitual obstetric risk, in order to exclude any situation that could justify the use of interventional practices during the birth process.

The national Birth in Brazil Survey about the way of giving birth and being born in the country demonstrated an excess of unnecessary interventions in women at usual risk and a low incorporation of recommended practices for childbirth and birth care in the hospital services included in the study.⁹

In the institutional form, the presence of the companion was described in two moments: companion in the pre-childbirth period and companion during childbirth. Only the latter was analyzed in the study, and there was a higher prevalence of companions during the birth of primiparous mothers.

A study found that the continuous support provided by the companion during the birth process is characterized as a mitigating factor by favoring the reduction of harmful interventions and practices

Table 1

Characterization of parturients at habitual obstetric risk seen at a tertiary hospital in Fortaleza, CE, Brazil, July 2017 - July 2018.

Characteristics	N	%
Age (years)		
14-19	79	25.2
20 - 34	214	68.2
35 - 39	18	5.7
40 or more	3	1.0
Origin		
Fortaleza	251	79.9
Metropolitan region	42	13.4
Countryside	19	6.1
Not informed	2	0.6
Education Level		
Elementary School	88	28
Incomplete high school	67	21.3
Complete high school	121	38.5
Incomplete university education	11	3.5
Complete university education	4	1.3
Not informed	23	7.3
Occupation		
Unpaid work activity	207	65.9
Paid work activity	76	24.2
Not informed	31	9.9
Prenatal		
Yes	308	98.1
No	4	1.3
Not informed	2	0.6
Pregnancies		
Primiparous	137	43.6
Multiparous	177	56.4
Total	314	100.0

Table 2

Obstetric practices related to childbirth care and usual risk birth in a Tertiary Hospital in Fortaleza, Ceará, July 2017 - July 2018.

Variables/Categories	N	%
Category A - Confirmedly useful practices that should be encouraged		
Freedom of position and movement	227	72.3
Presence of companion	208	66.2
Completion of the partograph	209	66.6
Offer of liquid diet	204	65.0
Use of non-pharmacological methods for pain relief*	172	54.8
Massage	115	66.8
Pelvic swing	82	47.6
Breathing exercises	60	34.8
Pelvic exercises	46	26.7
Others	62	36.0
Cord clamping in a timely manner	256	81.5
Breastfeeding in the childbirth room	233	74.2
Skin-to-skin contact	232	73.9
Category B - Clearly harmful or ineffective practices		
Venoclysis	133	42.4
Oxytocin infusion	91	29.0
Trichotomy	28	8.9
Lithotomy Position	21	6.7
Enema	1	0.3
Category C - Practices without sufficient evidence		
Amniotomy	35	11.1
Kristeller maneuver	6	1.9
Category D - Practices frequently used inappropriately		
Episiotomy	22	7.0

*The sample varied due to the possibility that several methods were performed on a parturient.

Table 3

Incidence of demonstrably useful practices that should be encouraged during labor and childbirth at usual risk, according to sociodemographic characteristics, Fortaleza, CE, Brazil, July 2017 - July 2018.

	Presence of companion (%)	Completion of the partograph (%)	Freedom of position and movement (%)	Use of non-pharmacological methods for pain relief (%)	Offer of liquid diet (%)
Age (years)					
14 to 19	28.4	24.9	28.2	29.0	26.5
20 to 34	67.3	68.4	65.2	65.7	66.7
35 to 39	3.8	5.7	6.2	4.7	5.9
40 or more	0.5	1.0	0.4	0.6	0.9
Origin					
Fortaleza	80.3	80.9	83.7	79.6	78.4
Metropolitan region	13.5	14.3	12.3	15.7	16.7
Countryside	6.2	4.8	4.0	4.7	4.9
Occupation					
Unpaid work activity	67.3	68.4	65.2	59.9	65.2
Paid work activity	22.6	21.5	24.7	28.5	25.0
Not informed	10.1	10.1	10.1	11.6	9.8

continue

Table 3 concluded

Incidence of demonstrably useful practices that should be encouraged during labor and childbirth at usual risk, according to sociodemographic characteristics, Fortaleza, CE, Brazil, July 2017 - July 2018.

	Presence of companion (%)	Completion of the partograph (%)	Freedom of position and movement (%)	Use of non-pharmacological methods for pain relief (%)	Offer of liquid diet (%)
Education					
Elementary School	23.1	26.8	27.3	23.3	27.9
Complete high school	41.8	38.3	39.2	40.7	40.2
Incomplete high school	22.6	23.9	23.4	22.1	19.6
Complete university education	1.0	1.4	0.4	0.6	1.5
Incomplete university education	4.3	2.4	3.5	5.2	3.4
Not informed	7.2	7.2	6.2	8.1	7.4
Pregnancies					
Primiparous	52.9	43.1	45.8	51.2	47.6
Multiparous	47.1	56.9	54.2	48.8	52.4
Total	66.2	66.6	72.3	54.8	65.0

Table 4

Incidence of clearly harmful, inappropriate practices without scientific evidence during labor and childbirth of usual risk according to sociodemographic characteristics, Fortaleza, CE, Brazil, July 2017 - July 2018.

	Enema (%)	Trichotomy (%)	Venoclysis (%)	Amniotomy (%)	Kristeller maneuver (%)	Oxytocin infusion (%)	Episiotomy (%)
Age (years)							
14 to 19	-	42.8	22.6	25.7	-	22.0	27.3
20 to 34	100.0	53.6	69.9	68.5	100.0	71.4	72.7
35 to 39	-	3.6	6.8	2.9	-	6.6	-
40 or more	-	-	0.7	2.9	-	-	-
Origin							
Fortaleza	100.0	71.4	81.2	85.7	100.0	82.4	86.4
Metropolitan region	-	17.9	14.3	11.4	-	13.2	4.5
Countryside	-	10.7	4.5	2.9	-	4.4	9.1
Occupation							
Unpaid work activity	100.0	89.3	64.7	74.3	66.7	67.0	68.2
Paid work activity	-	7.1	27.0	17.1	33.3	23.1	27.3
Not informed	-	3.6	8.3	8.6	-	9.9	4.5
Education							
Elementary School	-	28.6	23.3	22.9	16.7	22.0	4.6
Complete high school	100.0	35.7	41.4	37.1	66.6	45.0	63.6
Incomplete high school	-	28.6	20.3	22.9	16.7	20.9	31.8
Complete university education	-	3.6	1.5	2.9	-	2.2	-
Incomplete university education	-	3.6	6.0	5.7	-	3.3	-
Not informed	-	-	7.5	8.5	-	6.6	-
Pregnancies							
Primiparous	-	50.0	45.1	45.7	66.7	47.2	72.7
Multiparous	100.0	50.0	54.9	54.3	33.3	52.8	13.6
Total	0.3	8.9	42.4	11.1	1.9	29.0	7.0

at a time when the mother and baby are susceptible to hospital routines and the decisions of the professionals.¹⁰

It is also noteworthy that to ensure the presence of the companion of the woman's free choice, it is necessary the inspection of organs responsible in the health institutions linked to the Unified Health System (SUS) or supplementary health, as well as changes in the training of professionals for childbirth care.¹⁰

In this context, this right was guaranteed by Law number 11.108/2005, that ensures the presence of a companion of the women's choice during labor, childbirth, and puerperium in health services, within the scope of the SUS.¹¹ It is known that there are limitations that still prevent full adherence to this practice, such as professional, structural or financial issues. It is necessary that health institutions adapt and offer a structure capable of accommodating companions, guaranteeing and respecting this right of women.¹²

As for the monitoring of the progress of labor through the partograph, it was observed that the largest portion of care was provided through this instrument, mainly in the group of women who experienced one or more pregnancies. However, it was not possible to assess whether the completion of the partograph occurred correctly and/or completely, since this information was not included in the Monitoring Sheet of Labor and Childbirth Care. Thus, the use of this graphic representation of labor makes it possible to monitor its evolution, document, diagnose changes and indicate the adoption of appropriate measures to correct deviations from normality, also helping to avoid unnecessary interventions.¹³

With regard to freedom of position and movement, the institutional form made it possible to identify a higher incidence of multiparous women who walked around the room in the first stage of labor. A study points out that the adoption of upright positions and movement of the parturient during the first stage of labor reduces its duration and does not seem to be associated with increased intervention or negative effects on the well-being of mothers and babies.⁹

A systematic review on freedom of movement and positions in the first stage of labor showed that encouraging walking and alternating a vertical position has been indicated as advantageous for the woman and the fetus. Since, physical and physiological action associated with the vertical position, compared to the dorsal lithotomy position, confers beneficial effects, specifically in the progression of labor, in the reduction of pain and in the quality of

uterine contractions and maternal-fetal circulation.¹⁴

This reinforces the need to guide the parturients regarding the free choice of the position during childbirth and the benefits for better obstetric results. Women need to have access to correct information about the different positions they can adopt during childbirth, and not just comply with norms and routines already established by the institution. Allowing the lithotomy position to be part of a rigid and immutable hospital routine goes against the humanization of care.¹² In this sense, the study institution provides, through the multidisciplinary and uniprofessional residency in obstetric nursing, educational actions for professionals and conversation circles for pregnant women hospitalized, aiming at the humanization of care.

Furthermore, non-pharmacological methods for pain relief during labor were present in half of the analyzed sheets, with a higher prevalence found in the group of primiparous women. Methods should be offered to parturients, since their admission to the unit, for better management of labor and better perinatal results. Its use is beneficial, as it offers alternatives and comfort measures, improving childbirth care.¹²

Considering these aspects, providing women with conditions to tolerate pain and discomfort is one of the most important professional practices in obstetric care during labor. This reinforces the concern of health professionals involved in care in offering comfort and support to parturients in coping with pain.²

As for the practice of offering a liquid diet during labor, there was prevalence in the group of multiparous women. A study revealed that the practice of restricting oral intake during labor is due to the risk of pneumonitis due to aspiration of stomach contents, which can occur as a complication of an eventual general anesthesia. However, this risk is very low and this restriction can lead to dehydration, ketosis and prolonged labor, especially in women with low-risk pregnancies.¹⁵

In this sense, a qualitative research analyzed the eating experiences of women during childbirth, and identified that dietary management was superficially approached, with fasting prevailing in the care of parturients and, at the same time, women valued food at that time, relating it with the good development of childbirth.¹⁶

The adoption of good birth care practices is based on respect for the adaptation of the newborn to the extrauterine environment. Thus, it was evident that most newborns were submitted to umbilical cord clamping in due course or after stopping the pulsa-

tion. A study highlights that newborns that had timely clamping of the umbilical cord at least one minute after birth had a higher ferritin level than those who had immediate clamping of the cord, reducing the risk of developing anemia in early childhood. However, there are discussions that associate the appearance of polycythemia and jaundice with the fact that the newborn receives more blood, increasing the risk of excess red blood cells.¹⁷

Another practice confirmedly useful and recommended is skin-to-skin contact at birth. More than half of newborns were placed in direct contact with the mother's skin. Early skin-to-skin contact is a safe, inexpensive practice with proven benefits in the short and long term for mothers and children, justifying its implementation in Baby Friendly Hospitals (BFH).¹⁸

Breastfeeding in the childbirth room was performed in more than half of the newborns. The practice of early breastfeeding, within the first hour after birth, protects the newborn from acquiring infections and reduces neonatal mortality, is part of good birth care practices and should be encouraged. In addition to reducing infant mortality rates, there are several benefits that breastfeeding brings to the baby, including the ease of eliminating meconium, protection of the gastrointestinal tract against infections, promotion of attachment and reduction of the risk of jaundice.¹²

As a limitation found in the present study, the absence of complete records in the Monitoring Sheets of Labor and Childbirth Care, referring to the practices of skin-to-skin contact and breastfeeding in the childbirth room, was highlighted, with a percentile of 14% and 9.2%, respectively. In addition, the impossibility of measuring the duration of such practices was highlighted, since this information was not included in the sheet.

It is important to emphasize that the health professionals, especially nurses, was responsible for filling out these sheets. This filling was often performed by professionals not directly involved in childbirth care. Thus, it is necessary to raise awareness of professionals regarding the correct registration of practices, considering that underreporting limits the verification of actual data.

Findings related to clearly harmful or ineffective practices during labor, showed that the enema was prevalent in women who had given birth before. The practice of trichotomy was equivalent between primiparous and multiparous women. Enema and trichotomy should not be routinely performed during labor; they are non-beneficial interventions and can be uncomfortable.¹

As for the intravenous infusion of fluids (venoclysis), the study showed a higher incidence of this practice in multiparous women. A national survey identified a venoclysis rate of 73.8% for women at usual risk and 76.7% for those at high risk.⁹ A Cochrane systematic review concluded that there is insufficiently strong evidence to recommend the routine administration of intravenous fluids during labor, in addition to limiting the mother's mobility, maternal discomfort, fear and pain, and general negative feelings.¹⁹

Among the practices that should be used with caution in the first stage of labor, until further research clarifies the issue, it was found that amniotomy was more prevalent in multiparous women. The National Guideline for Assistance to Natural Childbirth recommends that early amniotomy, with or without oxytocin, should not be routinely performed in women in labor who are progressing well.¹

The "Being Born in Belo Horizonte Survey" (Nascer em Belo Horizonte) showed the practice of early amniotomy in 67.1% of women who went into labor, hospitalized with intact membranes. Furthermore, the acceleration of labor, whether with amniotomy and/or oxytocin, plays an important role in the "cascade of interventions" and in reducing the rate of spontaneous childbirth.²

The incidence of Kristeller maneuver was described mainly in primiparous women. Commonly used in situations such as fetal distress, lack of labor progress and maternal exhaustion, it is an obstetric maneuver performed during childbirth that consists of applying pressure on the upper part of the uterus in order to facilitate the expulsion of the baby, in the expulsive period of childbirth.²⁰ This practice lacks scientific evidence for its recommendation and can be considered a violation of the woman's bodily integrity, since it not only exposes her to risks but also causes discomfort and pain during its execution.²

In this study, the use of intrapartum oxytocin was more frequent in multiparous women. A study carried out in southern Spain described the effects of stimulation of labor with oxytocin and that its use can be harmful for both mother and newborn, since its use is related to an increase, in the rates of cesarean sections, use of epidural analgesia and intrapartum maternal fever, in primiparous and multiparous women.²¹

In contrast, the incidence of episiotomy rate was prevalent in primiparous women. A Cochrane's systematic review evaluating the effects of selective episiotomy versus routine episiotomy on vaginal

childbirth demonstrated that current evidence does not support the argument of performing routine episiotomy to avoid severe perineal trauma. Therefore, no benefit of routine episiotomy for the baby or mother was found.²²

Performing episiotomy routinely and indiscriminately in all parturients is not beneficial. However, failure to indicate the procedure, when there is a clinical situation in which its need is evident, is equally harmful.²³ Although data available in the literature has shown for years that this procedure does not meet the objectives that would justify its performance, episiotomy is still being abusively used in many health institutions.²

The study is limited by the underreporting of the practices recorded in the Monitoring Sheets for Care during Labor and Birth, which makes it difficult to provide a more reliable delineation of the local reality. The lack of important information on the institutional form should be also important: partograph fully filled out; skin-to-skin contact time and breastfeeding in the childbirth room; reasons that led to venoclysis, oxytocin infusion, amniotomy, Kristeller maneuver or episiotomy.

Another limitation of the study is the impossibility of identifying possible explanations for some relationships, such as: Why did multiparous women have a higher frequency of venoclysis, oxytocin infusion and amniotomy? Why did primiparous women undergo more episiotomy? Thus, it is suggested that further studies be carried out that can apply methods and investigate such relationships.

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Practices that have been shown to be useful and should be encouraged in childbirth and birth care were assured to most parturients at habitual obstetric risk. Although harmful practices based on the technocratic model were revealed, there was a prevalence of obstetric practices that support and adapt to the humanized model, from the perspective of care based on scientific evidence.

Importantly, evidence-based obstetric care includes a series of good practices that avoid iatrogenic or violent care in childbirth. In this context, good practices aimed at maternal and child care require a greater degree of training and updating, through continuing education. Essentially, the autonomy of the parturient must be respected, aiming at the adequate humanization of childbirth and birth care.

Therefore, it is necessary to disseminate good practices in institutions aimed at maternal and child care. It is hoped that the results of this study can support care on evidence-based practices, aiming to contribute to the improvement of obstetric care.

Author's contribution

Alcântara NA contributed to the design of the project, analysis, interpretation of the data and writing of the article. Silva TJP contributed to the critical review of intellectual content. All authors approved the final version of the article.

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