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PROFILE OF PREGNANT WOMEN AND USUAL RISK OBSTETRIC ASSISTANCE IN A PUBLIC MATERNITY

PERFIL DAS GESTANTES E A ASSISTÊNCIA OBSTÉTRICA DE RISCO HABITUAL EM UMA MATERNIDADE PÚBLICA

PERFIL DE GESTANTES Y LA ASISTENCIA OBSTÉTRICA DE RIESGO HABITUAL EN UNA MATERNIDAD PÚBLICA

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ABSTRACT

Objective: to outline the social and obstetric profile of women assisted at a public hospital. ***Method***: a descriptive, retrospective study with a quantitative approach carried out through documentary survey of 845 women assisted at a public hospital in the State of Rio Grande do Sul from June 2013 to June 2014. Data were analyzed using SPSS Software Program 10.0 and presented in tables. ***Results***: there was a predominance of young women with low education and unpaid work. There was a big use of obstetric interventions, highlighting the "active management" of labor and delivery. ***Conclusion***: the data indicate a transformation process of obstetric care practice, emphasizing the value and autonomy of professional performance of the obstetric nurse. ***Descriptors***: Gynecology; Labor; Delivery; Maternal and Child Health; Obstetric Nurses.

RESUMO

***Objetivo*:** delinear o perfil social e obstétrico das mulheres assistidas em uma maternidade pública. ***Método*:** estudo descritivo, retrospectivo, com abordagem quantitativa, realizado por meio de levantamento documental de 845 mulheres assistidas em uma maternidade pública do estado do Rio Grande do Sul, no período de junho de 2013 a junho de 2014. Os dados foram analisados no Programa Software SPSS 10.0 e apresentados em tabelas de contingência. ***Resultados*:** observou-se o predomínio de mulheres jovens, com baixa escolaridade e com trabalho não remunerado. Verificou-se a ampla utilização de intervenções obstétricas, evidenciando o "manejo ativo" do trabalho de parto e parto. ***Conclusão*:** os dados indicam um processo de transformação da prática assistencial obstétrica, enfatizando a valorização e a autonomia para atuação profissional da enfermeira obstétrica. ***Descritores*:** Obstetrícia; Trabalho de Parto; Parto; Saúde Materno-Infantil; Enfermeiras Obstétricas.

RESUMEN

***Objetivo*:** delinear el perfil social y obstétrico de las mujeres asistidas en una maternidad pública. ***Método*:** estudio descriptivo, retrospectivo, con enfoque cuantitativo realizado por medio de levantamiento documental de 845 mujeres asistidas en una maternidad pública del Estado de Rio Grande do Sul en el período de junio de 2013 a junio de 2014. Los datos fueron analizados en el Programa Software SPSS 10.0 y presentados en cuadros de contingencia. ***Resultados*:** se observó el predominio de mujeres jóvenes, con baja escolaridad y con trabajo no remunerado. Se verificó la amplia utilización de intervenciones obstétricas, evidenciando el "manejo activo" del trabajo de parto y parto. ***Conclusión*:** los datos indican un proceso de transformación de la práctica asistencial obstétrica, enfatizando la valorización y la autonomía para actuación profesional de la enfermera obstétrica. ***Descriptores*:** Obstetricia; Trabajo de Parto; Parto; Salud Materno-Infantil; Enfermeras Obstétricas.

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INTRODUCTION

The assistance to women during maternity underwent significant changes when delivery became a hospital and surgical event.[1] In Brazil, even with full coverage in prenatal care and hospital birth, there are elevated maternal mortality and perinatal mortality.[2] This context characterizes the "Brazilian perinatal paradox" highlighting the contradiction of excessive medicalization of childbirth with maintaining high rates of maternal and perinatal morbidity and mortality.[3]

Several practical assistance in pregnancy and childbirth promote better obstetric outcomes and are effective in reducing adverse perinatal outcomes. However, excessive medicalization and performing unnecessary interventions can provide losses mainly to the pregnant women of usual obstetric risk and their babies. These practices directly influence the quality of obstetric care provided.[2-3]

The contemporary obstetric care drives worldwide a critical reflection movement and the questioning of the interventionist model.[4] This movement, which seeks to humanize the care, reflects the need for changes in the understanding of birth as a human experience. Thus, humanize care at birth involves changing attitudes and routines to make this unique and pleasurable moment for the woman and her family.[5]

By the way, the Ministry of Health has proposed Comprehensive Care Policies on Health, which assume commitments to guarantee citizenship, sexual and reproductive rights to the woman and child. Although these initiatives are relevant, they have been insufficient to reverse the obstetric care model of Brazil, with the world´s highest cesarean rates as the greatest expression.[3,5]

Based on this understanding, the present study aims to:

- Outline the social and obstetric profile of women receiving care at a public hospital.
- Estimate the prevalence of obstetric interventions during labor of women assisted at a public hospital.

METHODOLOGY

A quantitative, descriptive and retrospective study, carried out through a documentary survey. The research took place at a maternity hospital located in the state of Rio Grande do Sul/RS, which is focused on meeting the usual obstetric risk situations and having a philosophy the Humanization of assistance to childbirth and birth. By being configured as a public institution, its assistance is geared towards patients of the Unified Health System (SUS). The population studied consisted of women who had their labor and childbirth assisted on this place under study, within one year, between July to December 2013 and from January to July 2014.

This study had a total sample of women, and then those that could be classified as usual obstetric risk pregnancies were selected, excluding the diagnosis of maternal pathologies, gestational age out of 37-41 weeks, multiple pregnancy, non-cephalic presentation, birth weight below 2,500 grams or above 4.500g, and birth weight not appropriate for gestational age, remaining with 79.5% (845) of the women studied. Moreover, since the subject was focused on the analysis of labor, women who did not go into labor and those who had an elective cesarean section were excluded. There were 37 losses because the records did not contain the necessary information for the study.

The data collection procedure were through collecting information contained in medical records. For the record of information, an instrument created by the author was used, consisting of identification, sociodemographic, clinical and obstetric conditions, obstetric intervention and neonatal conditions.

From the obtained records, the outline of the social and obstetric profile of women assisted in the study institution-field proceeded. The social profile is understood as the origin, maternal age, marital status, occupation, and education level of the population being studied. The obstetric profile is known as parity, gestational age, cervical, uterine dynamic expansion and status of amniotic membranes at admission. The primary interventions while driving the labor and childbirth still related to obstetric profile were investigated, such as amniotomy, intravenous infusion of oxytocin and episiotomy. Regarding cesarean delivery, indications were described. The neonatal profile included in the study

variables of weight, sex and Newborn´s Apgar (NB).

Therefore, the data were tabulated using Microsoft Excel Software for storage. Upon completion of the collection and tabulation of data, it began the process of statistical analysis using the SPSS 10.0 software (Statistical Package for Social Sciences Inc., Chicago, USA). Univariate exploratory analyzes of primary and secondary variables and descriptive statistics were performed. From this process, the socioeconomic profile, demographic and life habits of women participating in the study were outlined.

The project was submitted to the Research Ethics Committee of the Franciscan University Center of Santa Maria, after evaluation and approval of the Research Committee designated by the institution, approved in the opinion 739564/2014. Care explained in the Guidelines and Standards involving Human Subjects were held, adopted by Resolution CNS 466/12.

RESULTS

In the outlined period in the studied maternity, 1063 births occurred, characterized by 825 normal births, 238 cesarean sections, and the average births per month, considering the 13-month study, was approximately 81.7 births. Regarding the socio-demographic characteristics, the study population was characterized by young women, aged between 15 and 24 years old, 55.38% (468), adolescents aged 12 and 18, constituted 18:58% (157) of the total group.[6-7]

These data are shown in Table 1 stressing that 45.21% (382) of the women had at least high school or incomplete higher education. Self-reported skin color was characteristic of the studied population, verifying that 68.76% (581) of women say they are white, and the marital status as single with 78.70% (665). For the occupation, 39.88% (337) they exercised remunerated activities and 60.12% (508) when asked said they performed their duties in a domestic environment or were students.

Table 1. Distribution of women studied, according to variables: education, color (self-reported) and marital status, Santa Maria - RS, 2013/2014.

Socio-demographic characteristics	N	%
Education		
Without education	4	0.47
Elementary School (1st to 4th grade)	52	6.14
Elementary School (5th an 8th grade)	381	45.1
High School or incomplete higher education	382	45.2
Higher education	26	3.08
Color (self-reported)		
white	581	68.76
Black	111	13.14
Brown	153	18.10
Marital Status		
Single	665	78.70
Married or consensual union	139	16.45
Divorced	14	1.66
Widower	27	3.19
Total	845	100

Concerning the origin, most women, 564 (66.74%) were from the municipality of Santa Maria and 281 (33.26%) come from nearby cities since the maternity, study field, acts as a reference for treatment of normal risk births of their Regional Health Division. Table 2, the cities of most origin of the women in the study can be better analyzed.

Table 2. Distribution of municipalities of origin of assisted women, Santa Maria - RS, 2013/2014.

Municipalities of origin	N	%
Santa Maria	564	66.74
Agudo	42	4.96
São Pedro do Sul	34	4.03
Restinga Seca	31	3.67
São Vicente do Sul	29	3.43
Cacequi	22	2.60
Júlio de Castilhos	15	1.77
Itaara	14	1.66
Faxinal do Soturno	13	1.54
Other	81	9.6
Total	845	100

Concerning to clinical-obstetric conditions of patients, most of the women (56.57%) were nulliparous. The data shows that 98.58% (833) of the women had prenatal care, and 64.97% of cases, started in the first quarter, and 71.71% had six or more consultations, as evidenced in Table 3. The monitoring of prenatal care, in particular, services was performed by 7.7% of women. Gestational age at labor was 40 weeks or more in 36.57% of deliveries. Among the 367 women with previous births, only 62 (16.89%) had a previous cesarean section.

When observing the admission records in the maternity ward, the following findings are verified: 51.6% (436) of the women were not in active labor, that is, they had no high uterine dynamics and minimum dilation of four centimeters; 41.3% (349) were admitted to the previous cervix between four and seven centimeters; and 5.2% (44) of seven centimeters and full dilation of the cervix. At admission, 80.1% (677) of the women had intact amniotic membranes, and from them, 39.4% (267) had spontaneous rupture of amniotic membranes during labor.

Table 3. Distribution of women according to clinical-obstetric conditions, Santa Maria - RS, 2013/2014.

Clinical-obstetric conditions	N	%
Previous births		
Nulliparous	478	56.57
Primipara	174	20.59
Secundipara	105	12.43
Multipara (three or more births)	88	10.41
Number of prenatal consultations		
Less than three consultations	85	10.06
Three to five consultations	154	18.22
Six to nine consultations	351	41.54
More than ten consultations	255	30.18
Quarter of starting prenatal		
First quarter	549	64.97
Second quarter	272	32.19
Third quarter	15	1.77
Not informed	9	1.06
Gestational age at the beginning of labor		
37 weeks to 37 weeks and six days	59	6.98
38 weeks to 38 weeks and six days	193	22.84
39 weeks to 39 weeks and six days	284	33.61
40 weeks to 40 weeks and six days	309	36.57
Amniotic membranes state on admission		
Intact	679	80.35
Broken	166	19.64
Total	845	100

As for the type of delivery, 695 (82.24%) were normal deliveries and 17.75% were a caesarean section (150). The most frequent indications for cesarean delivery in the reported records of the study population are shown in Table 4. It should be noted the fact that 406 (48%) medical records showed no information on the presence of free choice of the woman´s companion during delivery.

Most of the babies had good vitality at birth; 87.69% (741) had Apgar rate more than seven in the first minute of life, and 96.68% (817) had a rate higher than seven in the fifth minute of life. There were 67.45% of infants between 2,500 and 3500g at birth and 32.54% between 3500 and 4.500g. As for the sex of newborns, 437 (51.71%) were male, and 408 (48.28%) were females.

Table 4. Distribution of the Caesarean delivery frequencies according to their indications, Santa Maria - RS, 2013/2014.

Obstetric indications for cesarean section	N	%
Non-reassuring fetal condition	34	22.67
Cephalic-pelvic disproportion	69	46
Failed induction	7	4.67
Stop progression	26	17.3
Total	150	100

Referring to obstetric interventions, it was found that of 677 pregnant women who were hospitalized with intact amniotic membranes, 55.39% (375) were submitted to artificial rupture of it, as well as 63.43% (536) received an intravenous infusion of oxytocin during labor and delivery. Related to the perineal conditions, 34.24% (238) of women showed no trauma or if so, there has been designated as mild trauma (laceration grade I), as indicated in Table 5. The episiotomy was performed in 50.93% (354) and vertical position (standing, squatting or fours) during childbirth occurred in 3.16% of cases.

Table 5. Prevalence of obstetric interventions during labor and delivery, Santa Maria - RS, 2013/2014.

Obstetric interventions	N	%
Delivery position		
Lithotomic	616	88.63
Vertical	22	3,16
Other (semi-vertical or lateral)	57	8,21
Perineum conditions		
Intact	132	18.99
Episiotomy	354	50.93
Laceration grade I	106	15.25
Laceration grade II	89	12.80
Laceration grade III or IV	14	2.01
(1) Total	695	100
(1) Excluded 150 women who performed a cesarean section.		

It is noteworthy the number of normal births with medical assistance with 496 (71.4%) while 189 (27.2%) births were attended by residents in midwifery and 10 (1.44%) by clinical nurses. These data contradict the current obstetric care model.

DISCUSSION

The social profile of the study population showed young women with little education, single marital status and under unpaid working conditions. The finding of the few women who have paid occupation in the study is opposite to the trends of their increasing integration into the labor market. It is possible that the high percentage of women who reported not having a paid occupation is similar not only to age, little education because the level of education is a crucial variable for understanding the differences in reproductive health behavior of the population. Associated with young age, low education promotes unemployment and the economic and social dependence of women, as well as influencing the age of sexual initiation, number of children and even their mortality.[4,8]

In the analysis of delivery types, 17.75% of women underwent cesarean delivery. The cesarean rate in the studied institution is not far from the recommended by the World Health Organization, which in 1985 defined the cesarean delivery rate as not higher than 10-15% in all regions of the world. The rate of birth by cesarean section in Brazil are also opposed, which has one of the highest rates in the world, and has been cited as a clear example of abusing this procedure.[9]

The optimal rate of cesarean sections should aim better maternal and neonatal outcomes, considering the available health resources and maternal preferences.[1] In this context, the Ministry of Health, with the initiative called “Rede Cegonha,” proposes to change the care model of labor and birth

with the work of multidisciplinary teams, including midwifery, use of protocols and monitoring of indicators of services with funding of goals achievable.[3]

An important data to consider in this study was the stage of labor at the time of hospitalization. It is noted a larger number of women in the latent and out of phase of labor. Only 48.40% of the population of women studied were hospitalized at an appropriate time; that is at the beginning of the active phase of labor. According to the Ministry of Health, the hospital is justified in the latent phase in cases of difficulties in accessing the location of birth, gestational age greater than 41 weeks of pregnancy, previous cesarean and premature rupture of membranes. However, these data were excluded from the study population.[10]

When early admission was not established in the active phase of labor or without a clear indication, the length of stay of the mother increases, submitting her to the hospital unnecessarily and enhances the number of unnecessary interventions, such as early rupture of amniotic membranes and the intravenous infusion of oxytocin.[4,8] Therefore, it is evident the importance of educational activities that allow women giving birth distinguish the active labor, differentiating it from Braxton-Hicks contractions and looking for the hospital at the time more timely, when labor is established.[11]

Obstetric interventions are another important consideration. These findings constitute the so-called "active management" of labor, brought by some medical schools to reduce the duration of the second stage of labor, thus speeding up the process of childbirth.[2] In this study, it was found that interventions as the infusion of oxytocin and artificial rupture of the amniotic membrane techniques were widely used.

Amniotomy was practiced in 55.39% of the study population. In modern obstetric practice, it is recommended as part of the active management of labor approach. The relationship between risks and benefits of this intervention is considered in the literature. Among the benefits, there are the reduction in the duration of labor and reducing the use of synthetic oxytocin. On the other hand, it is observed a tendency to an increase in cesarean rates.[8] There are still doubts about its effects on women and newborns. However, the usual risk of labor should be a clear reason to justify this procedure.[4,8]

Concerning the use of oxytocin, it is observed that its indication was widely used. However, the Ministry of Health does not recommend the routine infusion of oxytocin in pregnant women of normal risk, as it is unnecessary and can be harmful and can produce adverse maternal and perinatal outcomes.[11-12] In addition, to interfering with the natural course of labor and the movement of the mother, the routine use of oxytocin is related to a most painful experience during labor, and their indiscriminate use can result in tachysystole and changes in uterus-placental perfusion and resulting in an iatrogenic cesarean section. It is noteworthy though that studies only analyzed the infusion of oxytocin are great and inconsistent.[4]

As for perineal conditions, and episiotomy was observed in a large number of women in this study, 50.93%. As recommended by the Ministry of Health, episiotomy is indicated in about 10% to 15% of cases, and only should be performed in necessary cases.[10] There were not records with the reasons for professionals to indicate this procedure. Currently, scientific evidence showed that episiotomy enhances the risk of perineal laceration of third and fourth degrees of infection and bleeding, without decreasing the complications of long-term pain and urinary and fecal incontinence.[2] They also demonstrate that the restricted use of episiotomy results in less perineal trauma, suture and healing complications.[4] In this perspective, the new clinical guidelines discourage its routine use in obstetric care.

It is noteworthy the percentage of women with intact perineum during childbirth, especially if including the first-degree lacerations, 34.24%. The factors for the occurrence of perineal lacerations may be related to several factors, but are not established. There is evidence that indicate as factors related to the professional attending the birth, maternal education, parity, duration of the second stage of labor, the previous perineal scar, the infusion of oxytocin, the position at delivery, the directed bearing down, the perineal protection maneuvers, weight and head circumference of newborns, among others.[13] The authors believe that this result

was possible due to the adoption of a new model of assistance by the study institution, as well as the insertion of the residency program in midwifery and consequently due to the higher number of births attended by nurses.

Despite the benefits of vertical positions for the woman and the fetus, the lithotomy position at delivery was a rule, reaching more than 88% of normal deliveries. When comparing the vertical or lateral lithotomy positions, there are important aspects highlighted such as the reduction of intense soreness and fatigue of women, the reduction of the second stage, decline in guided birth rates, episiotomy and obstetric interventions.[14] It is also noted the satisfaction of women to participate more actively in the labor as well as being the most comfortable position and facilitating the expulsion of the fetus.[2]

The stimulation by the vertical position of professionals does not follow a rigid protocol, as there is freedom of choice for the woman who could take the position according to her preference, since oriented. There are a variety of positions during labor. However, it is not a reality in most obstetric care services, since lithotomy is the routine and traditional position.[14] It is noteworthy also that of those surveyed births, those occurring in vertical positions were assisted in their entirety by resident nurses in midwifery.

About neonatal outcomes, it was observed that mostly newborns had an adequate weight for gestational age. Moreover, the high Apgar scores demonstrated good conditions of neonatal vitality, which therefore can be related to the timely indication of the route of birth.

About care delivery professionals, it was noticed the predominance of medical professionals, only 28.64% of vaginal deliveries were attended by non-medical professionals. Studies confirm that rates of obstetric interventions are highly correlated with childbirth care professional.[15-16] Similar results were also found in a systematic review published in the Cochrane Library, which suggests that the delivery models of care for low-risk women involving midwives (midwives or direct entry midwives) are associated with lower rates of interventions, the greater chance of spontaneous labor and greater sense of control by the woman.[17]

In this regard, since 1998, the Ministry of Health qualify midwives for their integration in normal delivery assistance as a qualified professional to the rescue of natural childbirth as a physiological event and provides dignity, security and autonomy to the women.[18] However, women considered at high risk must have medical assistance guaranteed, aimed at identification and early treatment of intrapartum complications.[12]

CONCLUSION

Regarding the characterization of the research subjects, most women were young, had no paid occupation and were single. Regarding obstetric conditions, most had the first pregnancy and held six or more visits to prenatal care by the Unified Health System. The results showed that Caesarean section rates, although high, are close to the values stipulated by the World Health Organization and indications observed are consistent with those outlined absolute indications.

Behaviors were identified that characterize the active management of labor, which are discouraged and proved to be harmful to women, as they may result in adverse maternal and perinatal outcomes. The extensive use of technology in care delivery and an interventionist assistance, based on unnecessary procedures reflecting directly on the quality of care was found.

At the same time, they attended the surveyed unit, practices recommended by the World Health Organization and Ministry of Health. It is considered that these data indicate a transformation process of obstetric care practice. It is believed that this fact is increased by the insertion of the Residency Program in Obstetric and the institutional support for the adoption of a less interventionist model. These findings emphasize the appreciation and autonomy for professional performance of midwife in the attendance scenario to normal frequent risk deliveries, considering the non-interventionist nature inherent in their training.

As limitations of this study, we consider the fact that it was conducted in a teaching hospital, and the participants are patients of the Unified Health System, which implies a different reality in socioeconomic and cultural terms, and questionable degree of generalizability to the general population.

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