FATORES ASSOCIADOS À HUMANIZAÇÃO DA ASSISTÊNCIA EM UMA MATERNIDADE PÚBLICA

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RESUMO

Objetivo: identificar fatores associados à humanização da assistência durante o trabalho de parto, parto e nascimento. Método: estudo quanti-qualitativo, transversal, descritivo, realizado em uma maternidade pública. Foi utilizado formulário para a coleta de dados. Os dados foram analisados por meio de estatística simples e tests de associação e pela técnica de Análise de conteúdo. Resultados: participaram do estudo 373 puérperas com idade média de 26 anos, pardas, com baixa escolaridade e baixa renda. Houve associação significante entre a presença do acompanhante e a liberdade para fazer perguntas; baixa escolaridade e menor informação; parto vaginal e desrespeito por parte dos profissionais; mulheres brancas e presença do acompanhante com maior satisfação. Quanto à percepção para melhoria da assistência, emergiram as categorias: abrangência, privacidade, informação, respeito, garantia do acompanhante e desejo pela cirurgia cesariana. Conclusão: a adequada estrutura física e dimensionamento de pessoal qualificado são necessários para garantir a assistência baseada em evidências, centrada na mulher, visando à garantia dos seus direitos. Descriptors: Satisfação do Paciente; Assistência à Saúde; Humanização da Assistência; Maternidades; Parto; Enfermagem Obstétrica.

ABSTRACT

Objective: To identify factors associated with the humanization of care during labor, delivery and birth. Method: this is a quantitative, cross-sectional, descriptive study carried out in a public maternity hospital. A form for data collection was used. Data were analyzed using simple statistics and association tests and by the Content Analysis technique. Results: there were 373 postpartum women with a mean age of 26 years old, with low educational level and low income participating in the study. There was a significant association between the presence of the companion and the freedom to ask questions; low education level and less information; vaginal delivery and disrespect by the professionals; white women and presence of the companion with greater satisfaction. Concerning the perception for better care, the following categories emerged: scope, privacy, information, respect, guarantee of the companion and desire for cesarean surgery. Conclusion: Adequate physical structure and skilled staffing are needed to ensure evidence-based, woman-centered assistance to ensure their rights. Descriptors: Patient Satisfaction; Delivery of Health Care; Humanization of assistance; Hospitals, Maternity; Parturition; Obstetric Nursing.

RESUMEN

Objetivo: identificar factores asociados a la humanización de la asistencia durante el trabajo de parto, parto y nacimiento. Método: estudio cuanti-cualitativo, transversal, descritivo, realizado en una maternidad pública. Fue utilizado un formulario para la recolección de datos. Los datos fueron analizados por medio de estadística simple y tests de asociación y por la técnica de Análisis de contenido. Resultados: participaron del estudio 373 puérperas con edad media 26 años, pardas, con baja escolaridad y baja renta. Hubo asociación significante entre la presencia del acompañante y libertad para hacer preguntas; baja escolaridad y menor información; parto vaginal y desrespeto por parte de los profesionales; mujeres blancas y presencia del acompañante con mayor satisfacción. Sobre la percepción para mejoría de la asistencia, surgieron las categorías: ambigüedad, privacidad, información, respeto, garantía del acompañante y deseo pela cirurgia cesariana. Conclusión: la adecuada estructura física y dimensionamiento de personal calificado son necesarios para garantizar la asistencia basada en evidencias, centrada en la mujer, visando a la garantía de sus derechos. Descriptores: Satisfacción del Paciente; Prestación de Atención de Salud; Humanización de la Atención; Maternidades; Parto; Enfermería Obstétrica.

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INTRODUCTION

The history of childbirth and birth has been progressively transformed over time.¹ In Brazil, up to the nineteenth century, it was centered on women and traditionally performed by midwives. In the middle of the XX century, it was progressively institutionalized, occurring the transformation of the role of the woman from subject to object in the process of childbirth and birth, culminating in the medicalization of the female body.²

The Brazilian model of childbirth care has been built on humanization initiatives and successful experiences in childbirth and birth care. The main objectives of this model are to reduce maternal and child morbidity and mortality, abusive cesarean rates and other unnecessary interventions, allowing women to experience pregnancy, childbirth and birth with safety and dignity.³

In this context, at the end of the 1990s, the Brazilian Ministry of Health launched the creation of Normal Birth Centers (NCC) as a strategy, in addition to encouraging and financing the training of obstetrical nurses.⁴ In 2011, the “Rede Cegonha” emerges, implementing a network of care that assures women the right to reproductive planning and humanized care to pregnancy, childbirth and the puerperium.⁵

In 2013, it resumed investment in the training of obstetrical nurses with the creation of residency, specialization and improvement courses in obstetric nursing. Also, in 2015, it redefined the guidelines for the implementation and authorization of ANC in the scope of the Unified Health System (SUS).⁶ Considering that Sergipe does not have ANC, the objective was to identify the factors associated with the humanization of obstetric care and women’s satisfaction attended at the high-risk public maternity hospital in Sergipe.

Given that the humanization of childbirth is related to a set of changes in obstetrical practices, identifying factors associated with ambience, privacy, satisfaction and respect for women’s autonomy, is a way of indicating the attributes necessary for care delivery and birth relationship is anchored in the rights of patients of the health system.⁷ In this sense, this study is timely to provide data that can support the implementation of the care model in accordance with the recommendations of the “Rede Cegonha”.

OBJECTIVE

- To identify factors associated with the humanization of care during labor, delivery and birth.

METHOD

This is a quantitative and descriptive cross-sectional study developed at the state maternity hospital located in the city of Aracaju, Sergipe. It is the only maternity of high complexity of the state that attends exclusively to SUS, working 24 hours with open door. Also, it assists women of habitual risk when they arrive in advanced labor, which makes the transfer unfeasible, or when they have already been pilgrims. It is also the final destination of women living in the border states, which leads to overcrowding.

The Obstetric Center, the unit of choice for this work, is divided into a pre-delivery group, delivery rooms and Post-Anesthetic Recovery Room (PACU). The prepartum is composed of six beds with common hospital beds, and to adapt the demand of this place, extra stretchers are placed and it has only one bathroom. The vaginal delivery room has a gynecological delivery table and the six-bed SRPA without toilet.

The sample was non-randomly, for convenience, composed of Sergipe women and surrounding states that met the following inclusion criteria: a puerpera who remained for at least 30 minutes preterm birth; with gestational age≥37 weeks; with the first 48 hours of postpartum. The estimated sample size was 373 puerpera according to the Barbeta formula,⁸ considering that in this maternity there are approximately 5,700 births per year and a sampling error of 5%.

Data collection was from November 2015 to February 2016. The collection instrument consisted of a form that included socioeconomic data and a previous and current obstetric history. The information was obtained through interview and documentary analysis carried out by the researchers.

The variables considered as vulnerability factors were: skin color, established as non-white ones that self-referred as brown, black or yellow. Social class, grouped according to the categories established in the classification of the National Household Sample Program (PNAD) of the Brazilian Institute of Geography and Statistics.⁹ For analysis, it was considered a vulnerability factor belonging to the extremely poor, poor or vulnerable social classes. Regarding the education level, the categories denominated “less than six years and equal or greater than six years” were
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chosen, considering that the complete lower primary education corresponds to five years of study. Regarding the age, it was considered full years on the day of the interview, and when categorizing, it was chosen for children under 17 years old, 17 to 19, greater than 35 and 20 to 35 years old, corresponding to early adolescence, late adolescence and elderly pregnant women, with higher obstetric risk, and ideal age for parturition, respectively.

Regarding the humanization practices in Table 1, such as: freedom to ask questions, receive information about the evolution of labor, feel respected by the professionals who provided care and were satisfied with the care received at the obstetric center, only the proportions equivalent to the “yes” answers were shown.

Statistical analysis was performed with Epi Info software version 7.0. Quantitative and categorical variables were expressed in measures of central tendency and absolute and relative frequencies, respectively. The results were presented by means of a table. Chi-square and/or Fisher’s exact tests were used to verify the association between vulnerability factors and characteristics of humanized care at childbirth and birth (Figure 1). Statistical significance was set at 5% (p <0.05).

To understand satisfaction, a guiding question was used so all the participants could report what they would like to have been different in the assistance received. Qualitative data were categorized, described and interpreted considering the essential steps of Bardin’s content analysis.10 Speeches were coded with numbers according to the participant’s inclusion sequence in the study, and six categories emerged in the results.

The research complied with the recommendations of Resolution 466/2012 of the National Health Council and approved by the Research Ethics Committee of the Federal University of Sergipe (Opinion: 1,288,982). All participants and/or legal guardians signed the Informed Consent Term (TCLE). It should be noted that the professional categories reported by the puerpera were not identified.

RESULTS

During the collection period, there were 1,806 parturients assisted, and the sample consisted of 373 puerpera, which corresponds to 21.0% of the population assisted in this period. In this study, the vaginal delivery route prevailed, 258 (69.2%) [95% CI=64.5% - 73.9%].

The women interviewed had a mean age of 26 years old, with 86 (23.1%) adolescents (age <20 years old). Most women, 229 (61.4%), declared themselves to be brown; had a stable partner, 319 (85.5%); had low education level, corresponding to elementary school, 210 (56.3%); and belonged to social classes classified as extremely poor, poor or vulnerable, 240 (64.3%).

As to previous and current history, 171 (45.8%) puerpera were primiparous, of which 154 (90.0%) were primigravida. Almost all of the puerperal women, 369 (98.9%), reported prenatal follow-up in the last gestation, which was performed in most cases, 321 (86.1%) by SUS; 237 (64.2%) started it was during the first gestational trimester; 270 (73.2%) performed six or more consultations.

When questioned about access to maternity, 214 (57.4%) reported pilgrimage, of which 117 (54.7%) used transportation on their own to move between institutions and 25 (11.7%) spent in two or more maternity wards before arriving at this institution.

Table 1 shows the absolute and percentage values of the characterization of factors considered as vulnerability, humanization practices and general satisfaction regarding the assistance received during labor, delivery and birth.

There was greater freedom to ask questions among women who had partners (p=0.04), and there was no significant association with the other vulnerability factors. On the other hand, puerperal women with lower incomplete primary education received less information about the evolution of labor (L) (p=0.03).

Concerning the perception of the participants related to the respect of the professionals, the women who gave birth vaginally felt more disrespected (p=0.006). The highest satisfaction with the care received was associated with white self-reported skin color (p=0.03) and presence of the companion (p=0.04).

As for the guiding question: “What would you like to have been different in your care?”, six categories emerged:

Category 1: Improvement in ambience and physical/operational structure.

I would like more space in the delivery room. It was very tumultuous, hindering to get better care (NUM 139).

(...) which did not take so long in the intervals of the evaluations, practically I was only evaluated at the beginning of each shift (NUM 156).

(...) lack of a seat for the companion (NUM 169).

Category 2: Privacy.

I wanted the exposure to be less. All the patients having children in the corridor were already emotionally shaken to still see...
the deliveries being made in the corridor (NUM 47).

(...) wanted more privacy (...). The exhibition leaves us embarrassed (NUM 131).

I would like to have an escort (...) and enter the delivery room (No. 204).

I wish I could have had an escort (...) and that it was my husband (No. 271).

Category 3: Presence of a companion.

I wish I had a relative with me at that moment that was shaken (NUM 142).

(...) I would like to have been asked better... that they had talked about how I was going during labor (NUM 152).

Category 4: Desire for cesarean surgery.

(...) I felt that the professionals were stressed with overcrowding and affect the patients in the obstetric center (NUM 86).

When the touch exam was being performed, I stretched my leg and ended up beating the arm of the professional who verbally assaulted me (NUM 135).

(...) I would like to have been respected by the professionals, not to hear cries of them. And also being able to participate in the decisions, they did not tell me that the cut was going to be done, they just did it. And I was not able to give birth normal, my baby was 4 kg and did not go out, it was only born because they pushed my belly (NUM 199).

Category 5: Right to information.

I would like to be informed about the medications I was receiving (NUM. 187).

(...) I think the professionals should talk and explain about the procedures (NUM 191).

Factors associated with the humanization...

### Table 1. Vulnerability, humanization practices and satisfaction factors with delivery and birth care.

<table>
<thead>
<tr>
<th>Vulnerability factors</th>
<th>Freedom of asking</th>
<th>Information on L evolution</th>
<th>Respect for professionals</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Skin color</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-white</td>
<td>262</td>
<td>83.7</td>
<td>263</td>
<td>84.0</td>
</tr>
<tr>
<td>White</td>
<td>55</td>
<td>91.7</td>
<td>55</td>
<td>91.7</td>
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<tr>
<td>Social class**</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely poor</td>
<td>28</td>
<td>90.3</td>
<td>25</td>
<td>80.6</td>
</tr>
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<td>Poor</td>
<td>51</td>
<td>81.0</td>
<td>52</td>
<td>82.5</td>
</tr>
<tr>
<td>Vulnerable</td>
<td>124</td>
<td>84.9</td>
<td>120</td>
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<tr>
<td>Low middle class</td>
<td>56</td>
<td>88.9</td>
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<td>90.5</td>
</tr>
<tr>
<td>Average middle class</td>
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<td>78.8</td>
<td>29</td>
<td>87.9</td>
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<td>High middle class</td>
<td>14</td>
<td>93.3</td>
<td>14</td>
<td>93.3</td>
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<tr>
<td>Low upper class</td>
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<td>&lt; 6 years</td>
<td>83</td>
<td>86.5</td>
<td>75</td>
<td>78.1</td>
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<tr>
<td>≥ 6 years</td>
<td>234</td>
<td>84.5</td>
<td>243</td>
<td>87.7</td>
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<td>Age</td>
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<td></td>
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<td></td>
</tr>
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<td>&lt; 17</td>
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<td>93.3</td>
<td>28</td>
<td>93.3</td>
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<td>17 - 19</td>
<td>47</td>
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<td>45</td>
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<td>20 - 35</td>
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<td>205</td>
<td>86.9</td>
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<td>&gt; 35</td>
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<tr>
<td>Type of childbirth</td>
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<td></td>
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<tr>
<td>Vaginal</td>
<td>219</td>
<td>84.9</td>
<td>219</td>
<td>84.9</td>
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<tr>
<td>Cesarian</td>
<td>98</td>
<td>85.2</td>
<td>99</td>
<td>86.1</td>
</tr>
<tr>
<td>Companion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>236</td>
<td>83.1</td>
<td>240</td>
<td>84.5</td>
</tr>
<tr>
<td>Yes</td>
<td>81</td>
<td>91.0</td>
<td>78</td>
<td>87.6</td>
</tr>
</tbody>
</table>

*p-value: < 0.05

* L: Labor

**There were 19 puerpera waomen excluded because of lack of information.

***Lower primary education (<6 years of education), higher primary education (6 - 9 years of education), high school (10-12 years of education).
### DISCUSSION

Safe care based on the best evidence and respecting the physiology of childbirth is a right to be guaranteed to women regardless of their clinical, social or demographic particularities. However, this study demonstrated that some of these characteristics may be associated with non-adoption of practices considered humanized in the care of labor, delivery and birth.

The puerperal women who had companions had more freedom to ask questions, confirming that the presence of the companion in the process of parturition strengthens communication and bonding with other people for allowing them to express more safely, while solitude makes them vulnerable.\(^{11}\)

Additionally, the presence of the companion was associated with satisfaction with the assistance, since the support of a relative or friend, in comparison with any type of company, increases the satisfaction of the parturient in the experience of the childbirth, for providing confidence in the experience of the process in a quiet and participative way.\(^{12}\)

Women with less education received less information about the evolution of L. Also, it was possible to observe that no information was provided on the procedures carried out and their doubts were not adequately clarified, affecting the right to women-centered assistance. Clear, specific and simple language information provided by the team is fundamental for women's autonomy and role in decision making during the parturition process.\(^{11}\) If women had the necessary information, they might be more demanding and active, less passive and submissive.\(^{14}\)

Vaginal birth was associated with reports of disrespect, which may be due to the longer time in contact with the professionals during labor. The historical naturalization of gender violence, the domination of the female body by medicine and the marked asymmetry in the professional-patient relationship, turns women into an object of intervention.\(^{15}\)

In general, the participants in this study reported satisfaction with the assistance received, possibly because they still met the institution at the time of the interview and hesitate to criticize the care received and the professionals involved.\(^{16}\) It is noteworthy that those self-declared white people felt more satisfied. A similar situation was found in another study.\(^{6}\) Such a finding may be related to the historical ethnic-racial inequality in the assistance provided, where non-white women are exposed to a situation of vulnerability, violating the right to health and qualified access.\(^{17}\)

It was evidenced the desire of women to improve their environment and physical/operational structure. Since 2008, there are norms that regulate the structural characteristics of ANC with rooms that attend prepartum, delivery and postpartum (PPP). This format aims to rescue women's right to privacy and dignity by giving birth in a place similar to the family environment, with a structure that allows the adoption of a less interventionist model, which considers childbirth a physiological process.\(^{18}\)

On the other hand, the maternity in study still has collective prepartum, absence of separation between beds, shared bathroom, insufficient design of obstetrical nurses and, frequently, overcrowding. These factors have substantially hindered the guarantee of privacy, as well as be the main justification for noncompliance with the law of the companion.\(^{19,20}\) which guarantees the companion of free choice, and in the institution of the study, only the female companion is allowed. The absence of the father in the parturitive process can hinder the transition from parenting. A similar finding was found in other studies, in which the inadequate physical structure did not meet the needs for humanization of delivery care.\(^{21,22}\)

Also, only the minority of respondents had an companion during labor. The presence of the companion and his care for the parturient are essential to offer emotional and physical support, provide positive feelings and, in this way, make delivery and birth a pleasant experience.\(^{11}\)

Some interviewees expressed their desire for cesarean section surgery as an option for delivery. This may be due to the lack of

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**Table:**

<table>
<thead>
<tr>
<th>Vulnerability factors</th>
<th>Humanized childbirth care practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-white skin color</td>
<td>Freedom to ask</td>
</tr>
<tr>
<td>Less favored social class</td>
<td>Receiving information on the evolution of labor (L)</td>
</tr>
<tr>
<td>Vaginal delivery</td>
<td>Occurrence of violence</td>
</tr>
<tr>
<td>Absence of companion</td>
<td>Overall satisfaction with care received</td>
</tr>
</tbody>
</table>

Figure 1. Description of the investigated variables. Aracaju (SE), Brazil, 2016.
CONCLUSION

This study allowed the identification of non-white women, with no companions, with less education level and with vaginal delivery, had their rights less assured showing inequality in care, which reduced the satisfaction with the assistance received in labor, delivery and birth. Also, the ambience was determinant for the lack of privacy and absence of the companion.

It is suggested that the adequate physical structure and dimensioning of qualified personnel be necessary to guarantee the assistance based on scientific evidences, centered on the woman and the family, aiming at the humanization of care to childbirth and birth.

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