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Assessment of the assistance to eutocic delivery in a university hospital: a cross-sectional study

Alexandra do Nascimento Cassiano[1], Flávia Andréia Pereira Soares Santos[2], Kátia Cristina Araújo[3], Marquione Marques dos Santos[4], Jovanka Bittencourt Leite de Carvalho[5], Bertha Cruz Enders[6]

1 Federal University of Rio Grande do Norte

ABSTRACT

Objective: To evaluate the quality of assistance to eutocic delivery in a university hospital. **Method:** This is a cross-sectional, descriptive study with a quantitative approach, carried out during May 2015. The sample was obtained in a conventional way: women who have had eutocic deliveries were interviewed no more than 48 hours after delivery. Those who gave birth at home or en route to the hospital and those who were admitted already in the expulsive stage were excluded. The data will be analyzed using descriptive and inferential statistics, using the SPSS 20.0 software. The study was approved by the Research Ethics Committee under protocol no. 1.034.398. **Expected results:** It is believed that the study will contribute to improving the quality and safety of assistance to women during childbirth, aimed at the humanization of care to labor and delivery.

Keywords: Natural childbirth; Midwifery; Health Services Evaluation.

INTRODUCTION

From home birth—experienced within the family sphere and performed almost exclusively in the mother's house—to the hospital, the medical event, seen as a pathological and highly interventionist process, assistance to delivery is guided by the progress and changes in the society itself and in science. This reality favored the submission and the loss of autonomy by women throughout the birth process, leaving room for the indiscriminate use of interventional procedures at the time of delivery hospitalization.

Meanwhile, the delivery assistance model followed the technocratic paradigm, characterized by high rates of interventions performed routinely and without justifiable clinical indication. Among them, we can mention the performance of unnecessary cesarean sections; food restriction; routine use of episiotomy, Kristeller maneuver, forceps, and oxytocin; and the imposing of supine positions to the parturient. This is criticized by both the World Health Organization (WHO) and the Women's Health Care Policies[1]. Despite intensive discussions about humanized delivery care, the number of studies evaluating the quality of such care is still incipient. Therefore, it is important to quantify the quality of delivery care from indicators such as the Bologna Index, composed of five variables (presence of a companion in the delivery room, use of the partograph, lack of stimulation during labor, delivery not in a supine position, and contact of the newborn with the mother's skin, for at least 30 minutes in the first hour)[2]. According to the Index score, deliveries whose score is close to 0 are considered of low quality, whereas those with a value close to 5 show a better quality. In addition, the Protocol of Best Practices in Attention to Labor and Delivery is recommended by the WHO for the assistance to the mother and the newborn (also used as a parameter for the evaluation of delivery care)[2,3].

Objectives

This study aims to evaluate the quality of the assistance to eutocic delivery in a university hospital. The following specific objectives will be adopted:

- to identify the sociodemographic and obstetric profiles of pregnant women assisted at the university hospital;
- to determine the Bologna Index of eutocic deliveries;
- to check the use of the best practices in eutocic delivery care according to the WHO recommendations; and
- to correlate the quality of delivery care from the Bologna Index and from the categorization of the WHO best practices.

METHOD

This is a cross-sectional, descriptive study with a quantitative approach, carried out in a university hospital during May 2015. The study was developed in predelivery, childbirth and postpartum rooms and the rooming-in accommodations of the hospital, located in Santa Cruz, Rio Grande do Norte (RN).

The study population corresponds to the number of eutocic deliveries performed in the hospital, which has a current average of 83 births a month. The sample was obtained by convenience, by considering certain inclusion and exclusion criteria, reaching a total of 92 respondents.

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The study included mothers within 48 hours of low-risk delivery, whose children were born alive through vaginal delivery, with spontaneous labor, at term, and without dystocia. Those who presented the following conditions were excluded: those who gave birth at home, those who were on the way to the hospital, or those who have been admitted to the hospital already in the expulsive stage.

For the data collection phase, the birth log books and the patient records were consulted, and direct interviews were conducted with the mothers in order to fill the instrument developed by the author. The data collection process was only initiated after clarification to the subjects of the study objectives, risks and benefits of participation, and after they had signed the informed consent (IC).

The associated risks were related to the embarrassment in answering the questions and to the possible loss of patient records. The benefits included the knowledge of assistance to normal delivery according to the best practices in attention to labor and delivery recommended by the WHO.

For the inferential analysis, using the χ^2-test, we will check whether the values of the Bologna Index (up to 3 or > 3) differ significantly from the nominal categorical variables. A statistical significance level of 5% will be accepted for all the tests performed. The data will be analyzed using the Statistical Package for Social Sciences software (SPSS), version 20.0.

The study complies with the recommendations of Resolution No. 466/12 of the National Health Council, and was approved by the Research Ethics Committee of the School of Health Sciences of Trairí (FACISA), under protocol No. 1.034.398.

EXPECTED RESULTS AND IMPACTS

It is expected that, with the determination of Bologna Index and categorization of the best practices by the WHO, the incidence of the methods employed during normal delivery can be verified. Thus, we intend to facilitate the assessment of the quality of care provided to pregnant women and instigate reflection and (re)orientation of the care provided to them, in order to promote the humanization of care during labor and delivery.

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