

Good Obstetric Practices in Childbirth Care in

Boas Práticas Obstétricas na Assistência ao Parto em um Município do Nordeste Brasileiro

RESUMO

Objetivo: Identificar a adesão às boas práticas obstétricas na assistência ao parto a partir da percepção das puérperas. **Método:** Estudo descritivo, transversal e quantitativo, realizado com 326 mulheres no puerpério imediato, internadas em uma maternidade da Baixada Maranhense. A coleta de dados ocorreu entre abril e agosto de 2023, por meio de instrumento estruturado, e os dados foram analisados por estatística descritiva. **Resultado:** Observou-se baixa adesão às práticas recomendadas, destacando-se a limitação da liberdade de posição durante o parto, a ausência de acompanhante e a não realização da amamentação na primeira hora de vida. **Conclusão:** Apesar das recomendações nacionais e internacionais para a humanização da assistência obstétrica, as boas práticas ainda são pouco implementadas no contexto estudado, evidenciando a necessidade de qualificação da assistência ao parto.

DESCRIPTORES: Parto humanizado; Assistência ao parto; Obstetrícia; Período pós-parto.

ABSTRACT

Objective: To identify adherence to good obstetric practices in childbirth care from the perspective of postpartum women. **Method:** A descriptive, cross-sectional, and quantitative study was conducted with 326 women in the immediate postpartum period, hospitalized in a maternity hospital in the Baixada Maranhense region. Data collection took place between April and August 2023, using a structured instrument, and the data were analyzed using descriptive statistics. **Result:** Low adherence to recommended practices was observed, highlighting the limitation of freedom of position during childbirth, the absence of a companion, and the failure to breastfeed in the first hour of life. **Conclusion:** Despite national and international recommendations for the humanization of obstetric care, good practices are still poorly implemented in the studied context, highlighting the need to improve the quality of childbirth care.

DESCRIPTORS: Humanized childbirth; Childbirth assistance; Obstetrics; Postpartum period.

RESUMEN

Objetivo: Identificar la adherencia a las buenas prácticas obstétricas en la atención del parto desde la perspectiva de las puérperas. **Método:** Estudio descriptivo, transversal y cuantitativo realizado con 326 mujeres en el puerperio inmediato, hospitalizadas en una maternidad de la región de Baixada Maranhense. La recolección de datos se realizó entre abril y agosto de 2023 mediante un instrumento estructurado, y los datos se analizaron mediante estadística descriptiva. **Resultado:** Se observó una baja adherencia a las prácticas recomendadas, destacando la limitación de la libertad de posición durante el parto, la ausencia de acompañante y la falta de lactancia materna en la primera hora de vida. **Conclusión:** A pesar de las recomendaciones nacionales e internacionales para la humanización de la atención obstétrica, las buenas prácticas aún presentan una implementación deficiente en el contexto estudiado, lo que resalta la necesidad de mejorar la calidad de la atención del parto.

DESCRIPTORES: Parto humanizado; Asistencia al parto; Obstetricia; Posparto.

RECEIVED: 01/06/2026 APPROVED: 01/23/2026

How to cite this article: Ribeiro TC, Soares TML, Ribeiro LP, Sá DKS, Lopes GR, Santos ERS, Freitas DS. Good Obstetric Practices in Childbirth Care in a Municipality in Northeastern Brazil. *Saúde Coletiva* (Edição Brasileira) [Internet]. 2026 [acesso ano mês dia];17(104):19264-19279. Disponível em: DOI: 10.36489/saudecoletiva.2026v17i104p19264-19279

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INTRODUCTION

Good practices in labor and delivery care constitute a care model based on scientific evidence, with the aim of reducing unnecessary interventions and promoting favorable maternal and neonatal outcomes¹.

The humanization of obstetric care through the adoption of these practices is an essential strategy for overcoming the interventionist biomedical model, as it promotes women's autonomy, respect for the physiology of childbirth, and positive experiences of the birthing process, contributing to greater satisfaction, confidence, and safety^{1,2}.

In order to guide obstetric care, the World Health Organization (WHO) published recommendations for care during labor and delivery in 1996, which were subsequently updated in 2018³. In the Brazilian context, these guidelines were reinforced by public policies such as the Rede Cegonha (Stork Network), established in 2011, and the National Guideline for Normal Childbirth Care, published in 2016, which encourage practices such as respect for privacy, continuous support for the parturient, the use of non-pharmacological methods for pain relief, freedom of position and movement, as well as skin-to-skin

contact and breastfeeding in the first hour of life^{4,5}.

Despite regulatory advances, adherence to good obstetric practices still represents a challenge, since non-recommended interventions remain widely used in Brazilian maternity wards, in disagreement with World Health Organization guidelines, negatively impacting maternal and neonatal outcomes⁶.

Given this scenario, it is relevant to develop studies that analyze the care practices adopted in obstetric care, especially from the perspective of women. Thus, this study aims to identify adherence to good obstetric practices in childbirth care based on the perception of postpartum women, starting from the hypothesis that this adherence is partial or insufficient, reflecting the persistence of a care model centered on medical-hospital interventions and the limited incorporation of recommended practices for the humanization of care.

MATERIAL AND METHOD

This is a descriptive, cross-sectional, quantitative study linked to the research entitled *"Women's Knowledge and Experiences in Relation to Prenatal Care and Labor"*. The study was conducted at the Nossa Senhora das Mercês Maternal and Child Hospital,

located in the municipality of Pinheiro-MA.

The study population consisted of women in the immediate postpartum period after cesarean or vaginal delivery. Women diagnosed with mental illness or cognitive impairment were excluded.

For the sample calculation, data from the Live Birth Information System for the year 2020 in the municipality of Pinheiro were taken into account, in which 2,241 live births were registered, 2,133 (95.2%) at the Nossa Senhora das Mercês Maternal and Child Hospital. Based on this number, the sample was calculated considering a 95% confidence level and a 5% sampling error, totaling 326 women. The formula used for the calculation was: $n = N \cdot Z^2 \cdot p \cdot (1-p) / Z^2 \cdot p \cdot (1-p) + e^2$. $N-1$ (n : calculated sample, N : population, Z : normal variable p : actual probability of the event, e : sampling error)⁷.

Data collection for the study took place from April to August 2023 and involved the application of a structured questionnaire consisting of questions organized into blocks, namely: Sociodemographic, economic, and health characteristics; Obstetric data and aspects related to labor and delivery, developed based on national and international guidelines^{3,5}.

Before the instrument was applied,

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the participants were informed about the objectives of the research and, after agreeing, signed the Free and Informed Consent Form. For participants under 18 years of age, the Assent Form was used, requiring the signature of the Free and Informed Consent Form by a legal guardian over 18 years of age.

The data were tabulated in Microsoft Excel 2016®, and descriptive statistics were then performed to characterize the sample and distribute the frequencies of the different variables

analyzed. Descriptive analysis was performed, considering a 95% CI, using Jamovi 2.3.28, and the results

were presented in tables.

This study was submitted to Plataforma Brasil and approved by the Research Ethics Committee under opinion No. 5,984-505.

RESULTS

At the time of data collection, 453

women were approached, of whom 126 did not agree to participate in the study and 1 did not meet the inclusion criteria. Thus, 326 women participated in the study. Of these women, the majority were between 20 and 34 years of age (233, 71.5%), 138 (42.3%) had completed high school, 244 (74.8%) were brown-skinned, 212 (65%) were married/in a stable relationship, and 212 (65%) were unemployed. Regarding family income, 181 (55.5%) had an income of less than 1 minimum wage (Table 1).

TABLE 1. Sociodemographic characteristics and lifestyle of study participants. Pinheiro-MA, 2023.

Variable	N	%
Age Group		
< 15 years	2	0,6
15 to 19 years	62	19,0
20 to 35 years	233	71,5
35 years	29	8,9
Education Level		
No formal education	0	0,0
Incomplete elementary education	43	13,2
Complete elementary education	26	8,0
Incomplete secondary education	77	23,6
Complete secondary education	138	42,3
Incomplete higher education	22	6,8
Complete higher education	20	6,1
Race/Color		
White	24	7,4
Brown	244	74,8
Black	47	14,4
Yellow	5	1,5
Indigenous	3	0,9
Other	3	0,9
Marital Status		
Single	113	34,7
Married/Stable union	212	65,0
Widowed	0	0,0
Other	1	0,3
Has an occupation		
Yes	114	35,0
No	212	65,0

Household income		
Less than 1 minimum wage	181	55,5
1 minimum wage	85	26,1
Between 2 and 3 minimum wages	54	16,6
Other	6	1,8
Total	326	100,0

Source: Prepared by the authors

Regarding obstetric data, 144 (44.2%) of the women reported that it was their second or third pregnancy, 268 (82.2%) and 291 (89.3%) were between 37 and 41 weeks pregnant at the time of delivery (Table 2).

TABLE 2. Description of the obstetric profile of study participants. Pinheiro-MA, 2023.		
Variable	N	%
Number of pregnancies		
1 pregnancy	132	40,5
2 to 3 pregnancies	144	44,2
More than 3 pregnancies	50	15,3
Gestational age at delivery		
0–21 weeks	0	0,0
22–27 weeks	0	0,0
28–36 weeks	24	7,4
37–41 weeks	291	89,3
42 weeks or more	11	3,3
Total	326	100,0

Source: Prepared by the authors

Table 3 shows the types of delivery of the interviewees, where 159 (48.8%) of the women had a vaginal delivery and 167 (51.2%) had a cesarean section.

TABLE 3. Type of delivery of the study participants. Pinheiro-MA, 2023.		
Variable	n	%
Vaginal delivery	159	48,8
Cesarean delivery	167	51,2
Total	326	100,0

Source: Prepared by the authors

Good obstetric practices during labor and delivery in women who had cesarean and vaginal deliveries can be seen in Table 4.

Of the women who had vaginal deliveries, 101 (64.0%) received guidance on their labor, 8 (5.0%) were allowed to adopt the most comfortable position for delivery, 13 (8.0%) were allowed to have a companion during

delivery, 75 (47.0%) breastfed in the first hour of life, and 123 (77.0%) had skin-to-skin contact in the first hour of life, however, for less than 10 minutes, according to the women, corresponding to the period of placenta removal. Regarding pain relief methods, 58 (36.0%) used a Swiss ball, 49 (31.0%) were instructed on hip swaying and horseback riding movements, 106 (67.0%) were in-

structed on breathing exercises, 31 (19.0%) received lumbosacral massage, and 1 (1.0%) took a warm bath. None received other methods such as acupuncture, acupressure, auriculotherapy, aromatherapy, or epidural analgesia.

Regarding women who had cesarean deliveries, it is worth noting that this includes both women who went into labor and women who did not go

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into labor and had scheduled surgery.

Of the women who had a cesarean section, 72 (43.0%) received information about the progression of labor, 13 (8.1%) had a companion during delivery, 55 (33.0%) breastfed in the first hour of life, and 11 (7.0%) were placed in skin-to-skin contact in the

first hour of life. For pain relief methods, 32 (19.0%) used a Swiss ball, 26 (16.0%) were instructed on hip sway-

ing and horseback riding movements, 61 (37.0%) received guidance from professionals on breathing exercises,

and 11 (7.0%) received lumbosacral massage. Other methods such as warm water baths, acupuncture, acupressure, auriculotherapy, aromatherapy, and epidural analgesia were not offered. Of these women who underwent cesarean section, 142 (85.0%) were instructed by professionals on

TABELA 4. Caracterização das boas práticas durante o trabalho de parto e parto percebidas pelas mulheres. Pinheiro-MA, 2023.

Variable	Vaginal delivery		Cesarean delivery	
	N	%	N	%
Received information about the progression of labor				
Yes	101	64,0	72	43,0
No	58	36,0	95	57,0
Allowed to adopt the most comfortable position for childbirth				
Yes	8	5,0	0	0,0
No	151	95,0	167	100,0
Companion during childbirth				
Yes	13	8,0	13	8,0
No	146	92,0	154	92,0
Baby placed to breastfeed within the first hour of life				
Yes	75	47,0	55	33,0
No	84	53,0	112	67,0
Skin-to-skin contact within the first hour of life				
Yes	123	77,0	11	7,0
No	36	23,0	156	93,0
Use of a Swiss ball				
Yes	58	36,0	32	19,0
No	101	64,0	135	81,0
Guidance on pelvic rocking and "horse-riding" movements				
Yes	49	31,0	26	16,0
No	110	69,0	141	84,0
Guidance on breathing exercises				
Yes	106	67,0	61	37,0
No	53	33,0	106	93,0
Lumbosacral massage				
Yes	31	19,0	11	7,0
No	128	81,0	156	93,0
Warm water bath				
Yes	1	1,0	0	0,0
No	158	99,0	167	100,0
Acupuncture				
Yes	0	0,0	0	0,0
No	159	100,0	167	100,0

Acupressure				
Yes	0	0,0	0	0,0
No	159	100,0	167	100,0
Auriculotherapy				
Yes	0	0,0	0	0,0
No	159	100,0	167	100,0
Aromatherapy				
Yes	0	0,0	0	0,0
No	159	100,0	167	100,0
Epidural analgesia				
Yes	0	0,0	0	0,0
No	159	100,0	167	100,0
Informed by health professionals about the reason for cesarean delivery				
Yes	0	0,0	142	85,0
No	0	0,0	25	15,0
Not applicable	159	100	0	0,0
Total	159	100,0	167	100,0

Source: Prepared by the authors

DISCUSSION

The analysis of sociodemographic data showed that most women were between 20 and 34 years old, had completed high school, self-identified as brown, lived in a stable union or were married, had no formal occupation, and had an income below the minimum wage. This profile may directly influence experiences during childbirth and postpartum, since conditions such as lower education, reduced income, and unemployment are associated with limited access to information on reproductive rights and evidence-based obstetric practices, which may compromise the quality of care received. In addition, women in socially vulnerable situations are more exposed to outdated and potentially violent obstetric practices⁶.

With regard to good practices observed at the study site, there was low adherence to freedom of choice of birthing position, which is not in line with the recommendations of the World Health Organization³. Scientific evidence shows that the adoption of upright positions during

vaginal delivery is associated with improved maternal and fetal well-being, optimization of uterine dynamics, reduction in the duration of labor, and lower incidence of episiotomy, due to the biomechanical effects of gravity on the maternal pelvis⁸. Furthermore, a study conducted by Modi et al. (2023)⁹ demonstrated that the possibility of choosing the position was related to more positive experiences, with greater comfort and satisfaction of women in relation to the parturition process.

Regarding the presence of a companion, low adherence to the right guaranteed by Law No. 11. 108/2005, which guarantees the parturient the presence of a companion of her choice during labor, delivery, and immediate postpartum¹⁰. At the study site, only 8% of women with vaginal delivery and 8% of those undergoing cesarean section had a companion at the time of delivery, evidencing a discrepancy between current legislation and institutional practice.

The literature shows that the presence of a companion is associated with a greater sense of security and confidence, with positive repercussions

on the physiological evolution of childbirth and the strengthening of family bonds. In addition, a cross-sectional study found that the absence of a companion increased the prevalence of physical restraint during childbirth by 2.13 times, while their presence was associated with greater use of non-pharmacological methods and freedom of choice of birthing position¹².

Regarding breastfeeding, the World Health Organization recommends that it be initiated within the first hour of life, as it is associated with significant benefits for both mother and baby, including a reduced risk of postpartum hemorrhage and neonatal mortality, an increased likelihood of exclusive breastfeeding, and the strengthening of mother-baby interaction^{3,13,14}. However, in the scenario analyzed, this practice was not widely encouraged, especially among women who underwent cesarean sections. Recent studies indicate that vaginal delivery is associated with a higher chance of breastfeeding in the first hour of life when compared to cesarean delivery, highlighting the influence of the mode of delivery and

care practices on the timely initiation of breastfeeding.

With regard to non-pharmacological methods of pain relief, low adherence to these interventions was found in the maternity ward studied, especially among women who underwent cesarean sections. Only a portion of the parturients used resources such as Swiss balls, lumbosacral massage, and warm baths, in addition to receiving guidance on breathing exercises, pelvic rocking, and the use of a birthing stool, while practices such as acupuncture, auriculotherapy, and aromatherapy were not available. These findings corroborate the results of Costa et al. (2021)¹⁷, who also observed greater use of these strategies among women who had vaginal deliveries.

The literature recognizes non-pharmacological methods as central elements in the humanization of childbirth, promoting pain reduction, increased comfort, and decreased maternal anxiety, in addition to strengthening women's autonomy and avoiding unnecessary interventions, in line with the recommendations of the World Health Organization.

Regarding access to information, it was found that most women received guidance on the progression of labor and indications for operative delivery, constituting a favorable outcome in the context of the evaluation of obstetric care. However, the isolated presence of this practice is insufficient to ensure fully qualified care. The literature shows that effective communication, characterized by clear transmission of information, active listening, and a welcoming approach, has a positive impact on the childbirth experience by increasing maternal satisfaction, the perception of safety, and the feeling of control over the birthing process. In this context, by recognizing the parturient as an active subject of care, qualified communication assumes a strategic

role not only in improving the care experience, but also as a fundamental element in overcoming the techno-

cratic model that is still hegemonic in obstetric care.

Skin-to-skin contact in the first hour of life was more frequently reported among women who underwent vaginal delivery, while it was rarely observed among those who underwent cesarean section. However, even in vaginal deliveries, the practice was not effectively implemented, since the observed contact time was less than 10 minutes, contrary to the recommendations of the Brazilian Society of Pediatrics.

Evidence points to a significant difference in skin-to-skin contact between delivery methods, with a higher prevalence in vaginal delivery compared to cesarean section^{16,20}.

According to the guidelines of the World Health Organization and the United Nations Children's Fund (UNICEF), immediate and continuous skin-to-skin contact between the mother and the clinically stable full-term newborn should be ensured for at least one hour after birth, including in cesarean sections, in the absence of contraindications²¹. This practice contributes to skin colonization by the maternal microbiota, promotes neonatal thermal, glycemic, and hemodynamic stability, reduces the need for hospitalization, and is associated with the timely initiation and longer duration of breastfeeding, in addition to reducing the risk of postpartum hemorrhage, alleviating maternal pain, and promoting greater satisfaction for women and strengthening the mother-baby bond²²⁻²⁴.

Thus, labor and delivery care should be guided by a humanized care model based on scientific evidence. The systematic incorporation of practices recommended by the World Health Organization is a central strat-

egy for overcoming the still-predominant technocratic model, by favoring women's protagonism, improving the childbirth experience, and promoting greater maternal satisfaction, contributing to the consolidation of woman-centered obstetric care¹.

FINAL CONSIDERATIONS

The analysis of good obstetric practices showed that their adoption is restricted to a small proportion of women in labor, reflecting the persistence of a predominantly technocratic care model centered on medical and hospital interventions, to the detriment of an approach based on humanized care and women's needs.

The results highlight the persistent challenges for the effective implementation of woman-centered obstetric practices and offer relevant insights for the improvement of public policies and interventions aimed at reorienting the care model. A limitation of the study is the lack of distinction, at the time of data collection, between women who went into labor and those who underwent elective cesarean sections, which may have influenced the interpretation of the findings.

Given this scenario, we recommend future studies investigating continuing health education strategies in the context of Brazilian maternity wards, considering that the maintenance of outdated practices highlights the need for continuous training of professionals for the effective incorporation of good obstetric practices.

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