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ORIGINAL ARTICLE

Childbirth and newborn care: Progress and challenges of the Nascer Bem Movement in Caruaru

Atenção ao parto e nascimento: avanços e desafios do Movimento Nascer Bem Caruaru

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ABSTRACT This study evaluated the implementation of maternal and newborn care during labor and birth in a maternity hospital located in the rural region of Pernambuco, Brazil, with a focus on the contributions of the Nascer Bem Caruaru Movement. Employing an evaluative research design grounded in implementation analysis, the study adopted a case study approach with data triangulation and a mixed-methods strategy. Research techniques included interviews, direct observation, and document analysis. The analysis was structured around three contextual categories: government project, state capacity, and governability. The degree of implementation was assessed across five dimensions: activation of the care network and collaborative care practices, adherence to evidence-based practices, monitoring of care and outcomes, participatory and shared management, and the enabling environment. The maternity hospital demonstrated strong performance in several areas, including patient reception protocols, nurse-led obstetric care, the referral process for pregnant women, and the promotion of a care environment conducive to good practices. Municipal governance also showed potential to drive change, as evidenced by the enactment of Law No. 5,951/2017 on the humanization of care during pregnancy, childbirth, and abortion, and by reductions in infant mortality rates following the implementation of the Nascer Bem Caruaru initiative. However, key challenges remain, particularly in overcoming the entrenched interventionist model of childbirth care and addressing weaknesses in regional health governance.

KEYWORDS Health assessment. Implementation science. Perinatal care. Humanized birth.

RESUMO *O estudo avaliou a implementação da atenção ao parto e nascimento em uma maternidade no agreste de Pernambuco, com ênfase na contribuição do Movimento Nascer Bem Caruaru. Foi realizada uma pesquisa avaliativa do tipo análise de implantação, baseada em um estudo de caso com triangulação de dados e abordagem mista. Utilizaram-se as técnicas de pesquisa entrevista, observação e análise documental. As categorias do contexto foram projeto de governo, capacidade de governo e governabilidade; e do grau de implantação foram ativação de rede de atenção e compartilhamento do cuidado, boas práticas, monitoramento do cuidado e de resultados, gestão participativa e compartilhada e ambiência. Foi evidenciado um bom desempenho da maternidade nas diretrizes acolhimento, parto assistido por enfermeira obstétrica; vinculação da gestante à maternidade e ambiência adequada às boas práticas. Identificou-se potência na gestão municipal para indução de mudanças, com resultados como aprovação da Lei nº 5.951/2017, sobre a humanização da assistência à gestação, parto e abortamento e a redução dos índices de mortalidade infantil pós-intervenção do Nascer Bem Caruaru. Desafios a serem enfrentados estão relacionados com a dificuldade de superação do modelo intervencionista de atenção ao parto e nascimento e a fragilidade da governança regional.*

PALAVRAS-CHAVE *Avaliação em saúde. Ciência da implementação. Assistência perinatal. Parto humanizado.*

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Introduction

Public policies focused on labor and childbirth care, implemented in recent decades, have significantly contributed to reducing maternal and neonatal deaths worldwide[1]. A global study indicates that maternal mortality declined by 30% between 1990 and 2015[1]. However, new data reveal setbacks in maternal health in several regions of the world, highlighting the urgent need to intensify efforts to end preventable maternal mortality[2].

In Brazil, the Rede Cegonha (Stork Network) stood out for promoting good obstetric practices and providing safe childbirth care, aiming to reduce maternal and neonatal mortality[3]. In 2024, the Ministry of Health resumed this initiative with the launch of the Alyne Network, reinforcing its commitment to women's and newborn health[4].

Despite advances, inadequate obstetric practices and high rates of cesarean sections persist, often performed contrary to scientific evidence[5-7]. In Brazil, studies conducted in the Northeast region also point to the recurrence of these issues[8-10].

In the municipality of Caruaru, in the state of Pernambuco, an assessment carried out by the local government revealed a similar scenario, characterized by reports of obstetric violence, low adherence to good obstetric practices, and a high rate of cesarean sections, which in 2012 reached approximately 60%[11], well above the World Health Organization recommendation[12].

In response to this situation, the municipal health administration launched an interinstitutional initiative called the Caruaru Healthy Births Movement (Nascer Bem Caruaru Movement – MNBC). The effort brought together municipal departments, academic institutions, women's organizations, social accountability groups, and healthcare professionals, among others. Its primary aim was to transform childbirth practices in the city by empowering women and promoting safe, respectful, and humanized labor and birth experiences[11].

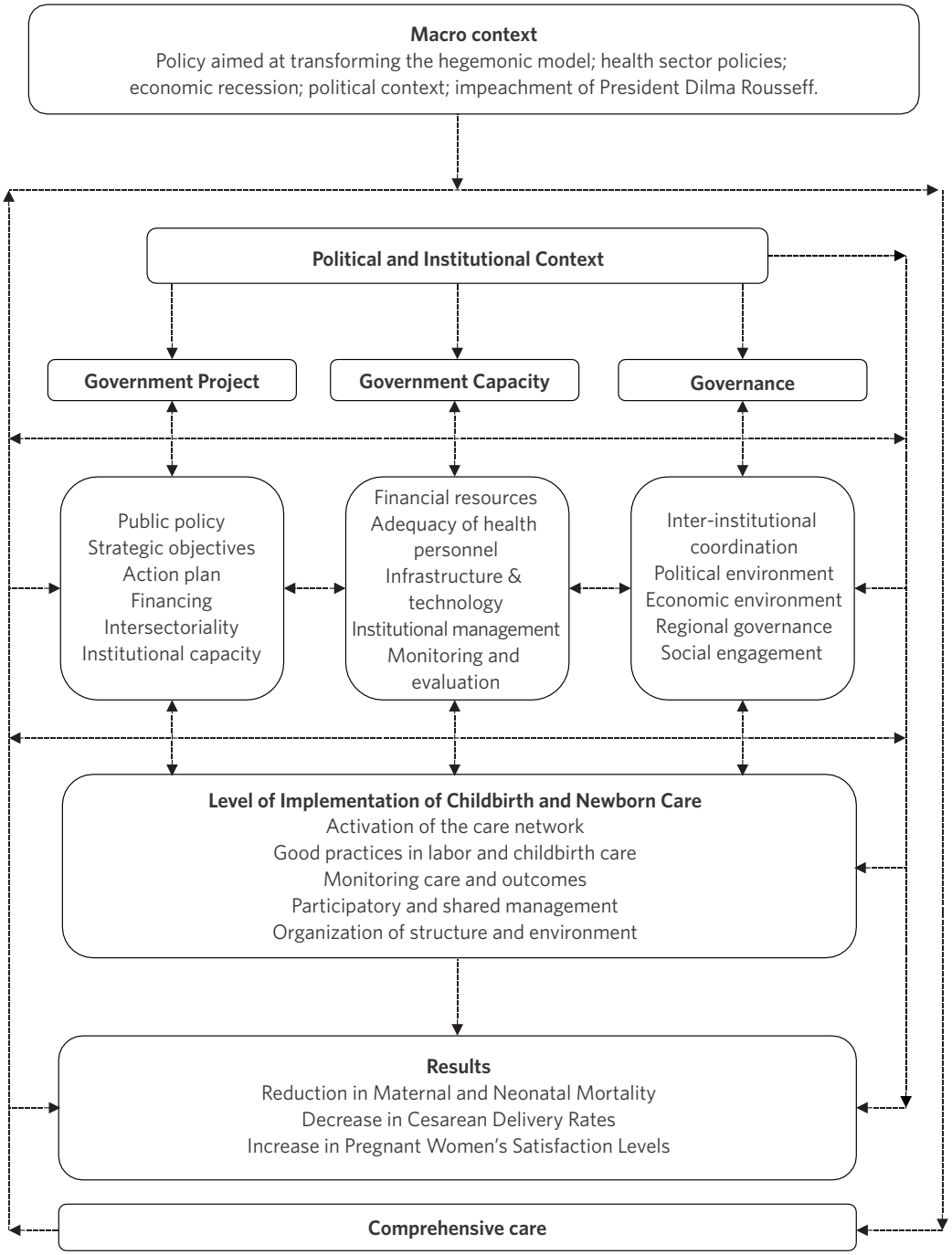
The initiative recognized the importance of ensuring women's access to information about their rights, as well as implementing institutional mechanisms to curb the normalization of abusive practices in labor and childbirth care[11]. Among the challenges in overcoming the dominant model of care were factors such as the fragmentation of the healthcare network, limited interprofessional collaboration, and weak regional governance[15].

Given the challenges posed by the proposed changes and the need to assess their impact, this article presents an evaluation of the implementation of an initiative designed to improve labor and childbirth care at a maternity hospital managed by the municipality of Caruaru, in the agreste region of Pernambuco.

Material and methods

This study is an implementation analysis conducted as an evaluative case study using data triangulation and a mixed-methods approach to assess the implementation of labor and childbirth care at the municipal maternity hospital in Caruaru, Pernambuco, between 2011 and 2024. The evaluation is grounded in the good practices promoted by the Rede Cegonha (RC). The theoretical framework of the study is presented in *figure 1*.

Figure 1. Theoretical framework of the study: illustrating how the political-institutional context and the level of implementation of labor and childbirth care influence intervention outcomes (2011–2024)



Source: Own elaboration.

In the initial qualitative phase, the political-institutional context was analyzed using a framework structured around the categories of government agenda, governmental capacity, and governability[17] (*box 1*).

Box 1. Analytical framework of the political-institutional context surrounding the implementation of labor and childbirth care in Caruaru from 2011 to 2024

Categories	Subcategories	Units of Analysis	Sources: Reference Documents / Key Informants
Government Program	Policy as a government priority	Existence of specific proposals for implementing labor and childbirth care	2013 Annual Health Program; 2014-2017 Municipal Health Plan Cegonha/Rami Network / Alyne Network
	Strategic objectives	Key goals and priorities established in the Government Program	Action Plan of Caruaru Birth Movement (Nascer Bem Caruaru)
	Intersectoral initiatives	Actions involving collaboration and coordination across different sectors or areas of activity	Managers from the Health Secretary, Women's Affairs Secretary, Social Participation Secretary, and a Representative from the Medical School/CAA
	Institutional capacity	The level of organization, coordination, and internal governance to ensure the system functions efficiently	Managers of Municipal Regulation and Specialized Care
Government Capacity	Financial Resources	Ability to mobilize and raise financial resources	2016 Annual Management Report
	Adequacy of the Health Team	Team qualification for implementing safe and humanized labor and childbirth care	Municipal managers and maternity ward professionals
	Infrastructure and Technology	Availability of appropriate technology and infrastructure for project execution	Action Plan for the *Nascer Bem Caruaru* Movement Municipal Information System Manager
	Project Management Capacity	Management expertise to operate services and programs	Managers of Specialized Care, Regulation, Information Systems, and the Maternity Ward
	Monitoramento e avaliação	Participation of civil society in the decision-making process and the implementation of the policy	Action Plan of the Nascer Bem Caruaru Movement
Governability	Inter-institutional coordination	Ability to foster cooperation with other governmental entities and diverse stakeholders	Managers from the Health, Women's Affairs Department, Social Participation Secretaries, and a University Representative
	Political support	Level of support from the media, political actors, and the parliament	Social Participation Secretary. A City Council representative, Municipal Health Manager
	Financial autonomy	Favorable or unfavorable economic conditions influence the implementation of the intervention	Manager of the Municipal Health Secretary, Public Health Budget Information System (SIOPS)
	Regional governance	Existence of a regional policy for labor and childbirth care with shared responsibilities and resource allocation	State Health Manager Resolutions of the Regional Inter-Management Commission (CIR-IV R) Members of the CT-CIR of the IV Region
	Social participation	Civil society participation in the decision-making process and the implementation of the policy	Managers of the Women's Affairs and the Social Participation Secretaries, City Council: assessment of postpartum women's perceptions regarding the care received in the Caruaru Health Network

Source: Own elaboration.

Document analysis and semi-structured interviews with key informants were conducted until data saturation was reached to gain an in-depth understanding of the context (*box 2*). The interviews were transcribed and subjected to Bardin's content analysis[18], guided by the frameworks of interprofessional collaboration[19], healthcare networks[20], comprehensive care[21], and governance[15].

Box 2. Key informants and documents used for the Qualitative Stage – Analysis of the political-institutional context

Representation of key informants	
Municipal Administration	Informant 1
Municipal Administration	Informant 2
Technical Chamber of the Regional Interagency – CIR IV Health Region	Informant 3
Municipal Administration	Informant 4
Pregnancy Support Center	Informant 5
Municipal Administration	Informant 6
State Administration	Informant 7
Women's Movement	Informant 8
University – Medical School / UFPE-CAA	Informant 9
Municipal Administration	Informant 10

Analyzed Documents
Ordinance No. 1,459, of June 24, 2011 – Establishes the Stork Network (Rede Cegonha)
Action Plan of the Nascer Bem Caruaru Movement – 2014
GM/MS Ordinance No. 715/2022 – Establishes the Maternal and Child Network (Rami)
GM/MS Ordinance No. 5,350/2024 – Establishes the Alyne Network
CIR IV Resolution No. 68/2011 – Approves the Stork Network in Region IV
CIR Resolution 119/2012 – Approves proposals for the construction, ambience, and acquisition of equipment for the Rede Cegonha for municipalities in the IV Health Region
CIR IV R Resolution No. 272/2015 – Modifies the design of the Rede Cegonha in Health Region IV
CIR IV R Resolution No. 297/2016 – Approves the construction of the Caruaru Municipal Maternity Hospital Facility
Annual Health Program of Caruaru 2012
Annual Health Program of Caruaru 2013
Municipal Health Plan of Caruaru 2014–2017
Municipal Health Plan of Caruaru 2018–2021
Municipal Health Plan of Caruaru 2022–2025
Annual Administration Report of Caruaru 2016
Annual Administration Report of Caruaru 2017
Annual Administration Report of Caruaru 2018
Annual Administration Report of Caruaru 2019
Diagnosis of the perception of postpartum women treated in the Caruaru Health Network in 2015
CIR Resolution No. 515/2024 approves the renegotiation of childbirth care references in the IV Health Region of Pernambuco

Source: Own elaboration.

In the second phase, the quantitative, the degree of implementation of the labor and childbirth care component at the municipal maternity hospital was assessed, focusing on service organization and care practices[22]. Data collection took place between 2023 and 2024 through medical record reviews, on-site observations, and structured interviews with closed-ended questions. Interviews were conducted with 11 obstetric nurses, one medical manager, one nursing manager, and 142 postpartum women, based on an estimated prevalence of 50% and a 95% confidence level. All individuals present at the maternity hospital on the days of data collection were invited to participate voluntarily, with respect for those who chose not to participate. For methodological reasons, physicians providing care were not interviewed; instead, clinical practices were evaluated through documentary analysis of medical records. This decision was based on the assumption that good practices should be properly documented in medical records in accordance with the Rede Cegonha guidelines[3], as adopted by the local management (Informant 1).

To assess the degree of implementation of labor and childbirth care, an evaluation matrix adapted from a nationally based study[23] was used. The criteria for judging the adequacy of

care were defined as follows: adequate (75.01% to 100%), partially adequate (50.1% to 75%), and inadequate (0% to 50%).

In the third phase, the study explored how the dynamic interaction between context and implementation strategies influenced the outcomes of labor and childbirth care[16], revealing complex and multidimensional relationships.

The study complied with Resolutions No. 466/2012[24] and No. 510/2016[25] of the Brazilian National Health Council and was approved by the Research Ethics Committee involving Human Subjects of Agamenon Magalhães Hospital, under opinion No. 5.974.484 and Certificate of Ethical Appraisal (CAAE) No. 67220322.2.0000.5197. All necessary precautions were taken to ensure the confidentiality and privacy of the information collected.

Results and discussion

The analysis of the study's findings was organized into three stages: an examination of the political-institutional context of the intervention; an evaluation of how fully the Rede Cegonha guidelines were implemented; and an analysis of how both the context and the level of implementation influenced the outcomes of the Nascer Bem Caruaru Movement (MNBC).

Analysis of the political and institutional context

DIAGNOSIS, POLITICAL DECISION-MAKING, PROPOSED ACTIONS, AND THE AUTHORITY TO CARRY OUT THE INTERVENTION

Caruaru is located in the agreste region of Pernambuco, 132 kilometers from Recife, the state capital, and has a population of 378,052[26]. The municipality serves as the regional and macro-regional health headquarters, concentrating the referral healthcare infrastructure for the IV Health Region (32 municipalities) and the II Macro-Region of Pernambuco (53 municipalities[26].

During the study period, the region registered approximately 18,000 births per year, of which approximately one-third were residents of Caruaru[26]. Most births took place in the state-run maternity hospital, which performed around 6,000 deliveries per year[27], serving as a referral center for pregnant women at regular risk in Health Region IV and high risk in Health Macro region II (Health Regions IV and V)[26]. Meanwhile, the municipal health system had 16 obstetric beds at the Hospital Geral, where roughly 2,300 births were performed each year[27].

As described by informants 1 and 2, the state maternity hospital was overwhelmed, offering just 0.07 beds per 1,000 residents who rely on the Unified Health System (SUS) – well below the recommended levels[28]. Combined with a shortage of municipal beds, this situation led to the routine transfer of pregnant women from Caruaru and surrounding areas to Vitória de Santo Antão and Recife, regardless of the level of obstetric risk. Faced with this critical scenario, the local government decided to overhaul the city's childbirth and maternity care system.

Thus, discussions began around establishing a maternal and child health network within the regional healthcare system, aimed at developing an RC Action Plan for the care network (Informant 3). This process led to an agreement that included the municipality of Caruaru, providing for the creation of a maternity unit for regular-risk births and a Natural Birth Center (CPN – the Portuguese abbreviation)[26].

Although the Rede Cegonha care network did not receive the expected funding from the three levels of government, as agreed in the Regional Interagency Commission (CIR) of the IV Health Region, the municipal government's plan still showed a strong commitment to building a new maternity hospital. According to Informant 4, the decision was

based on the understanding that the existing maternity ward at Hospital Geral lacked the proper infrastructure and systems needed to ensure safe and respectful obstetric care:

> *Most of the vaginal births were marked by violence. […] The way the maternity ward operated was deeply troubling. […] Women who were in labor or having abortions were all placed in the same room. The conditions were harsh – they had to lie down, remain naked, and be hooked up to IVs. Family members weren't allowed in, and there were no birth companions. They were left hungry, thirsty, and subjected to a range of obstetric interventions that are now recognized as forms of obstetric violence.* (Informant 4).

Violent obstetric practices, unnecessary interventions, high cesarean rates, and the need for pregnant women to travel from facility to facility were also reported in studies analyzing childbirth care in Brazil's Northeast region[5,8-10].

In response to these challenges, the municipal administration launched the MNBC in 2014 – an initiative designed to transform childbirth care practices within the municipality. The program focused on promoting women's autonomy and ensuring safe, respectful, and humanized birth experiences[11].

> *We set out to promote an ideological shift in how childbirth is experienced. The idea was to spark a broader movement, because isolated actions – whether in the maternity ward, in prenatal care, or through structural changes like painting and organizing – weren't enough. It needed to be a comprehensive effort, engaging the healthcare team, other municipal departments, and social movements.* (Informant 4).

A joint task force was created to assess obstetric care, examining aspects such as network-based care, access to services, and the use of best practices in childbirth. Based on this analysis, the group developed an intervention plan with clear goals and priorities aligned with key strategic objectives. These included organizing services into an integrated network, training and engaging both healthcare professionals and patients, improving access to care, and promoting collaboration across sectors[11]. The care model proposed by the RC served as a guiding framework for the municipal action plan[11].

An assessment of the institutional capacity to implement the project showed that the municipal administration was able to establish the internal governance conditions needed to achieve the proposed goals. One example of this effort was the development of the Operational Guideline for Equitable and Comprehensive Access, a tool that helped organize care flows and improve the quality of care:

> *The Maternal-Child module was created to ensure comprehensive access and care for pregnant women […] the flows were already managed by regulatory agents […] the innovation lies in the regulatory role becoming educational – not just a doctor there to authorize procedures […] they would be monitoring the network, identifying its shortcomings, and engaging in the ongoing education of these professionals.* (Informant 2).

THE MANAGEMENT'S ABILITY TO IMPLEMENT THE PROPOSED MODEL FOR LABOR AND CHILDBIRTH CARE

The government's ability to implement the intervention was seen as satisfactory in key areas such as political coordination and securing financial resources. Document analysis highlighted the municipal administration's skill in engaging strategic stakeholders and tapping into alternative funding sources, like parliamentary amendments, which made the construction of a municipal maternity hospital feasible. However, the reliance on off-budget resources reveals a structural weakness in the funding of public health policies, pointing to a lack

of coordinated and sustainable federal planning to ensure the implementation of proposed actions.

The administration's ability to manage services and programs was also noteworthy, demonstrated by its capacity to develop strategic plans and adapt to changing circumstances. This skill was cited as an example of institutional adaptability aimed at ensuring the effectiveness of implemented actions: "*A management unit was set up in the hospital because there was a lot of conflict [...] and there was a risk that the changes wouldn't go through – reinforcement was needed*". (Informant 1).

Interviews identified the team's lack of readiness to implement the intervention as one of the main challenges to driving organizational change, particularly due to the prevailing institutional culture centered on medical authority, consistent with findings in the literature[7]. It is important to note that the municipal maternity hospital did not face a shortage of staff; rather, the primary barrier was resistance from a team mostly trained under a traditional biomedical model to adopt new guidelines focused on humanizing childbirth. In response, management proposed a shift in the labor and childbirth model: "*We wanted the focus to be on the woman, with the team discussing interventions based on scientific evidence*" (Informant 4). Studies show that professionals tend to centralize decision-making during childbirth, often disregarding women's choices and thereby perpetuating practices marked by disrespect and abuse[29,30]. This situation clashes with the collaborative work model, which many authors recognize as essential for transforming professional practice and improving the quality of care[14,31,32].

The reports revealed that beyond resistance to the proposed changes, there was significant skepticism about their practical feasibility. To challenge this perception, the municipal administrators organized a visit to Sofia Feldman Maternity in Belo Horizonte, a benchmark for humanized labor and childbirth. This experience marked a symbolic break from the technocratic approach to birth: "*I was pregnant and went to Sofia Feldman Maternity with open ideas [...] so that this space of care and support could grow*" (Informant 5).

According to Informant 4, one outcome of the visit was the development of clinical care protocols by the maternity team. These documents were submitted for public consultation and later validated, helping to institutionalize best practices in labor and childbirth care: "*If we don't involve the workers in developing the protocols, there is a huge chance they'll just become meaningless documents. [...] That makes it much harder to get buy-in*" (Informant 4).

Regarding infrastructure and technology for network integration, Informant 6 reported that there were initially significant limitations, especially in rural areas. Over time, progress was made with the introduction of electronic medical records in Basic Health Units (BHUs) and the maternity hospital, allowing pregnant women's clinical histories to be available digitally and supporting continuity of care across different services. Nevertheless, despite having these tools, their full use still faces challenges related to staff training and engagement, which limit their potential to integrate care. This situation highlights the need to develop teamwork skills and effective use of health information, both essential for delivering comprehensive care[31,32].

In terms of monitoring and evaluation, there were no formal records of systematic processes designed to measure the performance and progress of the implemented actions, despite Informant 6 confirming that technologies for this purpose were available. This gap highlights a persistent challenge in public sector management: the still-incipient institutionalization of an evaluative culture. Without it, the ability to generate high-quality information to inform decision-making is compromised, limiting timely course corrections, hindering outcome measurement, and ultimately weakening both the sustainability and continuous improvement of the intervention.

POLITICAL AND SOCIAL CONDITIONS FOR EFFECTIVE GOVERNANCE

Despite a favorable political climate between 2011 and 2016, with alignment across municipal, state, and federal levels, this context did not result in the effective implementation of the RC in the IV Health Region.

In the following years, there was a back-and-forth between cooperation and conflict between municipal and state administrators, particularly concerning funding. The state government limited its financial support to high-risk maternity wards, while municipalities pushed for assistance to cover standard-risk maternity facilities as well (Informants 3 and 7). This deadlock hindered the establishment of a comprehensive and cooperative regional network within the CIR, highlighting the weakness of Pernambuco's role as a coordinating authority in driving regional policies. As a result, regional governance was undermined[33]. This finding aligns with Mendes' analysis[13], which argues that the consolidation of regional health networks requires structural changes in SUS management, care, and financing models, supported by decisions made within strengthened governance frameworks.

The lack of tripartite funding hindered the implementation of the agreed services in the regional network, placing additional strain on the state maternity hospital, which was already facing frequent admission blockages[9]. Moreover, the hospital's occupancy with low-risk deliveries limited access for high-risk pregnant women, who were supposed to receive priority care at that facility (Informant 3).

In this context, the municipal administration sought to strengthen its governance by forging strategic alliances with various stakeholders to create the conditions necessary for change. Partnerships were established with healthcare professionals, the municipal authorities, the Health Council, and the media, mobilizing both institutional and community support for the initiative (Informant 4). This strategy aligns with Matus' theory[17], which emphasizes the crucial role of strategic stakeholders in expanding governability.

Civil society also played a prominent role, with active involvement from the university and social movements coordinated by the Secretary of Women's Affairs and the Secretary of Social Participation. These groups engaged in discussions about the intervention project during a public hearing held at the City Council (Informant 4). A representative of the women's movement emphasized: "*the movement brought women to the forefront [...] a key indicator for evaluating labor and childbirth care is the mother's account of her experience*" (Informant 8).

The study identified the university as a strategic partner of the MNBC, serving as a technical advisor to the administration and lending greater credibility to the interventions implemented:

> *The way the Municipal Health Department responded to the arrival of the university – recognizing it as a window of opportunity – stood in contrast to what occurred in other cities, where new programs were introduced. [...] In some places, the university was perceived as a threat to the local power dynamics. [...] Achieving concrete outcomes during a period of financial constraint was only possible because of the deliberate choice to join forces and bring different actors together.* (Informant 9).

The MNBC went beyond the scope of a typical institutional intervention, fostering engagement and a sense of belonging among those involved:

> *Sometimes, in public management, we underestimate the need to engage people in decisions that will directly affect them – to stir their feelings, interest, attention, and involvement in the process.* (Informant 9).

There was a local strengthening of the intervention, including in the financial sphere, as evidenced by an increase in health investment

from 18.26% in 2011 to 27.18% in 2016 (Informant 10). However, the actions, collaborations, and funding allocated were impacted by shifts in the national and local political context, particularly following the impeachment of President Dilma Rousseff and the municipal government transition. These events highlight how political instability can undermine public interventions and jeopardize their sustainability, especially those requiring continuity and inter-institutional coordination[17].

Degree of implementation of recommended actions for labor and childbirth care

The implementation level of the recommended actions for labor and childbirth care was rated as partially adequate (70.8%) (*table 1*), mirroring results seen across most other regions of the country, except for the North region, where implementation was deemed inadequate[5].

Table 1. Level of implementation of labor and childbirth care component in a regular-risk maternity ward in Caruaru, 2024

Guideline / Strategy / Monitoring Indicator	Implementation rate (%)
Diretriz 1 – Ativação de redes de cuidado e compartilhamento de saberes	**77.6%**
Welcoming	88.5%
Introduction of professionals to users	72.2%
Addressing users by their first name	89.8%
Active listening to the complaints, fears, and expectations of users/companions	90.8%
Effective communication by maternity professionals	93.4%
Risk classification	35.5%
Risk classification by a specific professional for an activity and on a full-time basis	100.0%
Information for pregnant women about waiting times for care after assessment	34.3%
Network care and access	75.7%
Guarantee of the pregnant woman's linkage to the maternity hospital	91.6%
Guarantee of counter-referral from the maternity hospital to primary care	32.5%
Welcome and classification when hospitalization is indicated, even if no bed is available	100.0%
Guideline 2 – Good practices for labor and childbirth care	**72.6%**
Right to a companion of their choice	98.8%
Inclusion of a companion of their choice	99.2%
Guaranteed free access and stay for the newborn's parents in the neonatal unit	87.0%
Armchairs for companions during labor and delivery	100.0%
Guarantee of meal access for the companion of the postpartum woman	99.3%
Good practices in care for women during pre-labor, labor, and postpartum	52.8%
Good practices for caring for women during pre-labor, labor, and postpartum	100.0%
Normal low-risk delivery assisted by obstetric nurses	47.7%
Completed partograph	49.3%
Food offered to women at regular risk during labor	31.6%
Encouragement of ambulation during labor	86.5%
Encouraging non-supine positions for pregnant women during childbirth	77.3%
Avoidance of unnecessary interventions in women	78.1%
Amniotomy	61.1%

Table 1. Level of implementation of labor and childbirth care component in a regular-risk maternity ward in Caruaru, 2024

Guideline / Strategy / Monitoring Indicator	**Implementation rate (%)**
Venous access during labor	74.4%
Uterotonic drugs during labor	88.6%
Kristeller maneuver	96.2%
Episiotomy	75.5%
Guideline 3 – Monitoring care and outcomes of labor and childbirth care	**28.2%**
Monitoring and availability of indicators for labor and childbirth care	23.8%
The bed occupancy rate in shared accommodation and the neonatal unit	00.0%
The average length of stay in shared accommodation and the neonatal unit	00.0%
Monitoring of the proportion of cesarean sections	19.0%
Presence of a companion during hospitalization for childbirth	00.0%
Risk classification in the maternity ward	59.4%
Development of strategies to reduce the rate of cesarean sections	22.9%
Percentage of episiotomy in normal deliveries	03.8%
Monitoring and availability of maternal, neonatal, and fetal mortality indicators	62.5%
The number of maternal, infant, and fetal deaths made available to the work team	100.0%
Analysis of fatalities occurs regularly	52.6%
Dissemination of morbidity and mortality indicators to the maternity ward work team	12.0%
Guideline 4 – Participatory and shared management	**25.0%**
Management board or other collaborative management bodies	35.3%
Existence of a management board or other collaborative management body	24.1%
Participation of professionals from different functions in collaborative management bodies	27.0%
Participation of teams in decision-making on their work processes	41.0%
The management board or other management body meets regularly	32.5%
The existence of an ombudsman in the maternity ward	100%
Mechanisms for informing and listening to users, companions, and workers	23.5%
The maternity ward routinely makes decisions based on requests sent to the ombudsman	20.0%
Professionals are informed about reports forwarded to the ombudsman	84.6%
Guideline 5 – Organization of structure and environment	**100.0%**
A proper environment for good practices at the entrance	100.0%
A proper and comfortable environment for receiving women and their companions	100.0%
Comfort and privacy are ensured at the clinical examination and admission room for the women in labor	100.0%
A proper environment for good practices in labor and childbirth care	100.0%
Percentage of adequacy in the availability of pre-labor, labor, and postpartum rooms	100.0%
Percentage of adequacy of pre-labor, labor, and postpartum rooms	100.0%
A proper environment in the shared accommodation	100.0%
Assured comfort in the shared accommodation	100.0%
Appropriate environment in the Neonatal Unit	100.0%
Assured comfort in the Neonatal Unit	100.0%
Accessible environment	100.0%
Accessibility conditions for pregnant women and/or companions with disabilities	100.0%

Source: Own elaboration.

Note: Implementation score: 75.01% to 100% = adequate; 50.01% to 75% = partially adequate; 0 to 50% = not adequate.

According to the guidelines-based analysis, 'the facility's structure and environment' were fully compliant across all criteria. Notably, the availability of private rooms with en-suite bathrooms and hot showers provides women with privacy and comfort, key factors that support a positive labor experience[6]. As a standard-risk maternity facility, the municipal maternity hospital does not have a Neonatal Intensive Care Unit (NICU) or an Intermediate Care Unit. However, it is equipped with a neonatal care room that includes ventilators, heated cribs, incubators, and multi-parameter monitors to support newborn care. Accessibility was rated as adequate, with infrastructure in compliance with inclusion standards. These results surpass those found in a national study[5], which identified inadequacies in over 40% of maternity wards regarding welcome areas, risk classification, and clinical and admission examinations. Additionally, 43% were rated as having inadequate rooming-in conditions, and in 87% of cases, access conditions were also deemed inadequate[5]. Other studies further support the evidence of shortcomings in the structure and environment of maternity facilities[34,35].

The guideline on 'network activation and knowledge sharing' reached 77.6% compliance, with particular strengths in humanized care, attentive listening, and effective communication – all elements linked to greater satisfaction among postpartum women[29].

Another highlight was the 'linkage of pregnant women to a designated maternity facility,' a key quality indicator, which reached 91.6% – significantly above the national average (20.5%)[5]. On the other hand, 'clarification about risk classification' (34.3%) and the 'assurance of counter-referral to primary care' (32.5%) remained close to national figures, at 47.9% and 24.3% respectively[5], revealing persistent weaknesses. A study conducted in another municipality in Pernambuco also found that reception with risk classification was only partially implemented (61.4%)[34].

The guideline on 'best practices in labor and childbirth care' was rated as partially adequate, with a score of 72.6%. Positive highlights included the assurance of a woman's right to have a companion of her choice (98.8%), low-risk births assisted by obstetric nurses (100%), encouragement of mobility during labor (86.5%), and the use of non-supine birthing positions (77.3%). However, the provision of food (49.6%), access to non-pharmacological pain relief methods (31.6%), and completion of the partograph (47.7%) were deemed inadequate. These findings reflect a concerning national trend, particularly regarding the partograph, whose low use undermines the quality of care[5]. This is worrisome, given scientific evidence showing that proper use of the partograph helps reduce unnecessary interventions and contributes to better obstetric outcomes[6].

The guideline on 'avoiding unnecessary interventions on women' was rated as adequate (78.1%), with low rates of practices such as the use of uterotonic drugs (88.6%), the Kristeller maneuver (96.2%), episiotomy (75.5%), venipuncture (74.4%), and amniotomy (61.1%). Yet, illegible medical records in some charts made it difficult to verify certain information. Even so, the results were better than those of another study, in which this guideline was considered only partially implemented in the municipality (55.7%)[34].

On the other hand, 'monitoring of care and childbirth outcomes' was rated as inadequate (28.2%), revealing a lack of institutional culture around the systematic evaluation of processes and results. This situation hinders continuous quality improvement and reflects a national trend, with many maternity facilities showing weaknesses in this area[5].

Finally, the guideline on 'participatory and shared management' also showed poor performance (25%), highlighting the lack of spaces for listening to and valuing healthcare professionals, as well as the absence of effective mechanisms for responding to users' needs. These findings align with studies that point to structural shortcomings in the involvement of workers in collective management processes[5,34].

The influence of context and implementation level on outcomes

The study's findings show that, although the implementation of labor and childbirth care faced significant challenges, such as weak regional governance and the lack of properly allocated funding, the political and institutional context had a positive influence on the scope of implementation. There are indications that this condition supported the execution of actions that led to tangible benefits for the target population (*box 3*).

Box 3. Effects of the political-institutional context and implementation level on the outcomes of the childbirth and birth care component

Political-institutional Context	Level of implementation of labor and childbirth care	Products	Results
Rede Cegonha – 2011	Overall Result: Implementation Level (GI) partially adequate (70.8%)	Municipal Maternity	Women's satisfaction with labor care: 2015 = 97% positive rating
The political alignment of municipal, state, and federal governments – 2011–2016	Guideline Results (D): D1 – Activation of the Care Network = Adequate GI (77.6%)	Pregnancy Support Center Maternity Administration Board Medical bonus based on good obstetric practices Prenatal care protocols	Reduction in C-sections: 2012 to 2016 = 26.63% decrease
More Doctors Program: Provision of Medical Professionals 2013 - 2014	Reception = Adequate (88.5%)	Natural Birth Center	Reduction in maternal mortality by 66.5% between 2013 and 2022
Launch of the UFPE/CAA Medicine Course - 2014	Risk Classification = Not adequate (35.5%)	Conversion of obstetric beds in the general hospital into a 40-bed maternity ward Pregnant Women Component in the Operational Access Standard	Reduction in neonatal mortality by 46.8% between 2013 and 2021
Funding Acquisition for Maternity Services - Parliamentary Amendments - 2014-2015-2016	Network Care and Access = Adequate (75.7)	Technical Committee for Addressing Obstetric Violence	Women's satisfaction with labor care: 72.2% (2024)
Publication of Rede Cegonha Policy - 2011	D2 - Good practices in labor and childbirth care = Partially adequate GI (72.6%)	Law No. 5,668/2026 – Right to a companion of one's choice and a doula	Increase in cesarean sections: 55.4% between 2016 and 2019
Impeachment of President Dilma Rousseff - 2016	Right to a companion of one's choice (98.8%)	Law No. 5,622/2016 establishes the Integrated School Health System of the Unified Health System (SISE-SUS)	Increase in maternal mortality: 6.7% between 2019 and 2020
Change in municipal administration - 2017	Good practices in care for women (52.8%)	Municipal Law No. 5,951/2017 - Safe and Humanized Childbirth Doula Training Courses	Increase in neonatal mortality: 43.3% between 2021 and 2022
Discontinuation of the Nascer Bem Caruaru Movement - 2017	No unnecessary interventions (78.1%)	Training Courses for Expectant Parents	
Discontinuation of the Rede Cegonha - 2022	D5 - Organization of structure and environment = Adequate GI (100%)		
Pandemic COVID-19 - 2020-2023	Adequate environment and accessibility at the entrance door; in the PPP; in joint accommodation, and the Neonatal Unit (100%)		
Rami Network - 2022			
Alyne Network- 2024			

Source: Own elaboration.

Between 2013 and 2022, a downward trend in maternal mortality was observed, despite a spike in 2020, possibly linked to the impact of the COVID-19 pandemic. During the same period, neonatal mortality also showed a declining trajectory, even with an increase in the last two years of the series. These findings suggest that the intervention led to significant results, particularly during periods of greater political and institutional stability – a context that supported the expansion of MNBC initiatives.

The association between best practices, such as low-risk births assisted by obstetric nurses, the presence of a companion of the woman's choice, proper completion of the partograph, and the avoidance of unnecessary interventions, and the reduction of preventable mortality is well documented in the literature[2,36]. In this sense, local data support the hypothesis that the quality of care provided was a key factor in the outcomes achieved.

An analysis of cesarean deliveries between 2012 and 2016 shows a 26.63%[27] decrease, indicating a downward trend in surgical births during a period that coincides with the implementation of MNBC guidelines, which prioritized safe and humanized natural births[11]. However, between 2016 and 2019, there was a 55.4% increase in cesarean deliveries[27], reflecting a shift toward a hospital-centered, biomedical model focused on obstetric risk, to the detriment of a more comprehensive, humanized, and community-based approach[37].

Another important aspect relates to women's satisfaction with the care they received –an indicator that also reflected the positive impact of the intervention. Satisfaction rates with labor and childbirth care, although declining from 97% (2015)[38] to 72.2% (2024), remained relatively high. This reduction may be linked to institutional changes, including lower adherence to humanized practices and less effective intersectoral coordination. Studies assessing maternal satisfaction emphasize that labor is not merely a technical event, and that aspects such as humanization are essential to ensuring quality care[6,39].

The MNBC was most effective between 2014 and 2016, when several initiatives were implemented, notably the conversion of obstetric beds in the Hospital Geral into maternity beds, the establishment of a Birth Center (CPN), prior referral of pregnant women to the maternity ward, social mobilization to collect signatures for a popular initiative bill promoting a safe and humanized labor and childbirth, and the creation of the Technical Committee to Tackle Obstetric Violence (Informant 4). The post-2016 period, marked by changes in the national political landscape and a transition in municipal leadership, coincided with the discontinuation of MNBC initiatives and an upward trend in key indicators, maternal and neonatal mortality rates, and the cesarean section rate. These findings suggest a possible link between the discontinuation of MNBC interventions and the deterioration of obstetric outcomes, although other contextual factors cannot be ruled out.

The launch of the Alyne Network in 2024 represents a new chance for public administrators to reorganize the coordination of labor and childbirth care. By reaffirming the core principles of the Rede Cegonha, this new policy provides an institutional framework to restore evidence-based practices, clear guidelines to overcome the fragmentation seen in the previous period, and tools to realign the healthcare system with the principles of equity and comprehensiveness[4].

The Caruaru experience thus illustrates the complex interdependence between context, implementation, and outcomes, highlighting ways to continuously improve labor and childbirth care policies in Brazil.

Final considerations

Given that adverse maternal and childbirth outcomes are still frequently associated with

inappropriate practices, unnecessary interventions, and weak connections between pregnant women and maternity services, it becomes evident that the quality of care remains at the heart of the challenges surrounding labor and childbirth care.

In this regard, the findings of this study acknowledge that the interventions carried out by the MNBC, aligned with the Rede Cegonha care model and shaped by changes in the political-institutional context, fostered significant advancements in labor and childbirth care in Caruaru. This experience underscores the critical role of policies grounded in adequate financing, effective governance, and strong intersectoral political commitment.

The analysis reveals a synergy between the MNBC interventions, based on the RC care model, shifts in the political-institutional context, and the improvement of labor and childbirth indicators in Caruaru.

Significant progress has been made in improving the quality of care, including expanded access to the care network and enhanced infrastructure for labor and childbirth care. However, aspects such as the consolidation of good obstetric practices, shared care, participatory management, and the continuous monitoring of care and outcomes remain vulnerable to shifts in the political-institutional context, particularly in response to changes in the functioning of the health network, public policies, and transitions in leadership.

Thus, although the MNBC succeeded in implementing a new model of labor and childbirth care, the discontinuity of its actions had a negative impact on key indicators, reinforcing the notion that achievements in public health depend not only on the technical quality of interventions but also on the stability and coherence of public policies.

Following these changes, maternal and neonatal mortality rates rose, underscoring the urgent need for in-depth studies to examine the underlying causes of these deaths, especially those between 2021 and 2022, to assess any potential correlation with the impact of the COVID-19 pandemic.

Based on the reflections from this study, it is recommended to foster inclusive and participatory dialogue spaces among management, healthcare professionals, and service users, alongside strengthening collaborative work and ongoing education as key strategies to consolidate best obstetric practices. Such initiatives can contribute to institutionalizing interventions aimed at improving labor and childbirth care.

Furthermore, the importance of strengthening regional governance, particularly within the scope of the CIR, stands out as a core strategy to ensure the financing and organization of healthcare networks. To achieve this, it is essential to establish robust inter-management agreements that set clear goals, share responsibilities, and promote integrated and efficient management of the healthcare system.

Collaborators

Souza MA (0000-0002-5374-3487)* contributed to the conception and design of the study, data acquisition, analysis and interpretation, drafting of preliminary versions of the article, critical revision of its intellectual content, and approval of the final manuscript. Albuquerque PC (0000-0001-8283-5041)* and Figueiró AC (0000-0003-0718-5426)* contributed to the study design, drafting of preliminary versions of the article, critical revision of its intellectual content, and approval of the final manuscript. Jácome PRLA (0000-0003-3691-9716)* contributed to data analysis and interpretation, drafting of preliminary versions of the article, critical revision of important intellectual content, and approval of the final manuscript. ■

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