Review

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Barriers to implementing guideline recommendations to improve childbirth care: a rapid review of evidence*

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ABSTRACT

Objective. To identify potential barriers to the implementation of the National Childbirth Guidelines in Brazil based on the best available global evidence.

Method. A rapid review of evidence was performed in six databases in March/April 2019. Secondary studies published in English, Spanish, or Portuguese with a focus on barriers of any nature relating to the implementation of the Guidelines were retrieved.

Results. Twenty-three documents (21 reviews and two practice guides) were included in the review. The barriers identified were grouped into 52 meaning categories and then reorganized into nine thematic clusters: delivery and childbirth care model, human resource management, knowledge and beliefs, gender relations, health care service management, attitudes and behaviors, communication, socioeconomic conditions, and political interests.

Conclusions. The results show that combined approaches may be required to address different barriers to the implementation of the Guidelines. For successful implementation, it is essential to engage health care leaders, professionals, and users in the effort to change the delivery and childbirth care model. Also necessary is the development of intersectoral initiatives to improve the socioeconomic conditions of women and families and to curtail gender inequalities.

Keywords Evidence-informed policy; implementation science; practice guidelines as topic; parturition; Brazil.

While recent decades have seen important progress in Brazil in the care of pregnant women, parturient women, and newborns, challenges remain with regard to the quality of childbirth (1). The most visible challenge is the high rate of C-sections, which rose from 15% in 1970 to 56% in 2015, despite the adoption of several policy measures over the last two decades (1–3). Examples of recent initiatives by the Ministry of Health include the Rede Cegonha ("Stork Network", 2012), the Appropriate Childbirth program (2015), and the project on Improvement and Innovation in the Care and Teaching in Obstetrics and Neonatology (ApiceOn, 2017).

In addition to these initiatives, a set of National Care Guidelines for Normal Childbirth in Brazil were developed in 2017 (1, 4). The Guidelines contain 225 recommendations, divided into eight sections: 1) the place where childbirth care is provided; 2) general care during delivery; 3) pain relief during delivery; 4) care during the first stage of delivery; 5) care during the second stage of delivery; 6) care during the third stage of delivery; 7) immediate postpartum maternal care; and 8) care of the newborn (4).

Even though practical clinical guidelines like these are fundamental for ensuring quality health care, they can be underutilized

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(5) when their implementation is poorly planned or inefficient (6). In the planning process, it is important to identify potential barriers that might pose challenges for the various actors involved at the different levels of the health system (7). Therefore, the objective of the study presented here was to review the best available global evidence for identifying barriers to implementation of the recommendations in the National Care Guidelines for Normal Childbirth in Brazil.

MATERIALS AND METHODS

The present systematic review was conducted under the initiative Embedding Research for the Sustainable Development Goals, led by the Pan American Health Organization (PAHO). This report accompanies another article on the same topic in the current special edition: "Implementation of the National Childbirth Guidelines in Brazil: Barriers and strategies." A rapid systematic review was conducted using methodological shortcuts to produce a timely synthesis of the best available evidence in order to meet the specific demand for a public health policy (8). The protocol for this review is available in the Supplementary Material (page 1).

According to the criteria for inclusion, the articles were secondary studies only (systematic reviews, qualitative evidence syntheses, systematic mappings, narrative reviews, and clinical practice guidelines), published in English Portuguese, or Spanish, which addressed the subject of barriers to the implementation of one or more of the recommendations in the Guidelines.

The searches

The searches were conducted between 21 March and 1 April 2019. There was no limitation on the date when the articles were published. Six data sources were used. In the PubMed database MeSH entry terms associated with parturition ("Parturition," "Parturitions," "Birth," "Births," "Childbirth," "Childbirths") and guideline adherence ("Adherence, Guideline," "Policy Compliance," "Compliance, Policy," "Protocol Compliance," "Compliance, Protocol," "Institutional Adherence," "Adherence, Institutional"). In the Regional Portal of the Virtual Health Library (VHL) (https://bvsa-lud.org/), the health sciences descriptors (DeCS) in Portuguese were "parto normal" and "parto humanizado," with the search restricted to human subjects and to the Latin American Caribbean Health Sciences Literature (LILACS) and the Brazilian Nursing Database (BDENF). The term "Childbirth alone was used in the following sources: Health Systems Evidence (https://www.healthsystemsevidence.org/), Health Evidence (https://www.healthevidence.org/) and Epistemonikos (https://www.epistemonikos.org/). Further details on the searches are available in the Supplementary Material (page 5).

Data selection and extraction

The selection was done by two reviewers (CFO, AAVR) using the Rayyan QCRI platform (9). Disparities were resolved by consensus. The extraction was done by two researchers (CFO, AAVR) working independently and reviewed by another pair of researchers (MCB, TST), using a spreadsheet to record the data for the study and the barriers identified based on the level of health system organization (7).

Assessment of methodological quality

The systematic reviews were assessed in duplicate using the AMSTAR I tool (10) to rate their quality as low (score 0-3), moderate (4-7), or high (8-11). Disparities were resolved by consensus. In addition, when an AMSTAR I assessment was already available in the Health Evidence and Health Systems Evidence databases, the previous assessments were also taken into account. The methodological quality of the non-systematic reviews and clinical practice guidelines was not assessed.

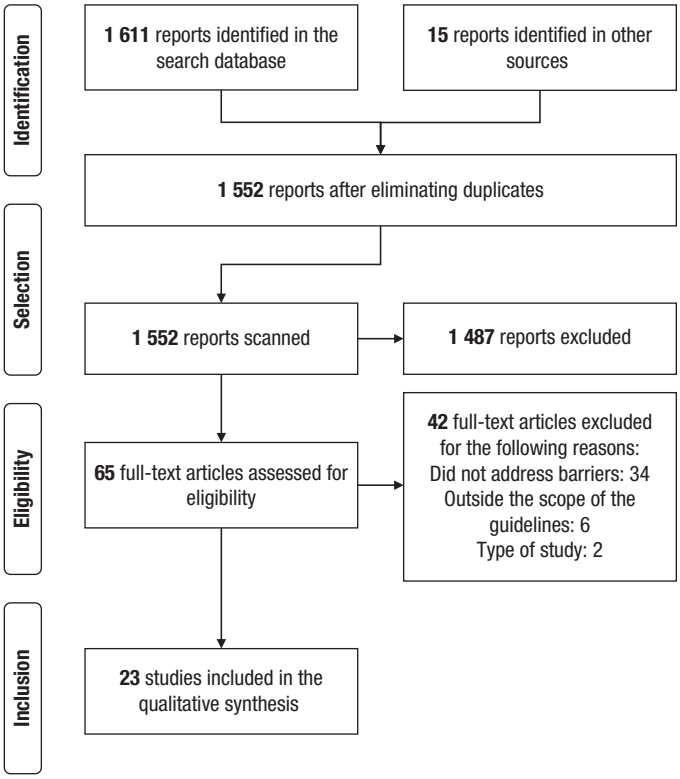
Summary of the findings

The barriers identified were grouped according to the methodological orientation of the thematic analysis (11). First, the reports were categorized according to common meanings taking into account the eight areas of the Guidelines and the organizational levels (health care users, personnel, services, and overall systems) (7). Next, the categories were analyzed again and regrouped according to similar thematic clusters.

RESULTS

The searches retrieved a total of 1,611 documents. In addition, 13 other articles and two sets of clinical practice guidelines, suggested by specialists, were also considered. As a result of the selection process, 42 studies were excluded (with justification), resulting in the inclusion of 23 studies in the synthesis of findings (Figure 1).

FIGURE 1. Study selection flow chart



Source: Own preparation based on the results of the present study.

Characteristics of the included studies

The final list comprised 10 systematic reviews, 5 qualitative evidence syntheses, 2 narrative reviews, 2 evidence maps, and 2 sets of clinical practice guidelines. The income status of the countries covered broke down as follows: high (36.1%), lower middle (31.8%), upper middle (20.3%), and low (11.8%). Of the systematic reviews, seven were of moderate quality, two of high quality, and one of poor quality (Supplementary Material, page 9).

The included studies addressed barriers that corresponded to five of the eight sections of the Guidelines: 1) place where the childbirth care is provided; 2) general care during delivery; 3) pain relief during delivery; and 4) care during the first stage of delivery; and 5) care during the second stage of delivery. The results related to 25 of the 225 recommendations in the Guidelines (Supplementary Material, page 15). A synthesis of the findings, grouped according to nine thematic clusters and 52 types of barriers, is shown in Table 1. Complete information is available in the Supplementary Material (page 18).

Delivery and childbirth care model

The thematic cluster with the most categories was the model of delivery and childbirth care, with challenges related to the health services and systems. Childbirth care is dominated by the biomedical model, which emphasizes the role of the physician to the detriment of other health professionals and dictates the practices that are followed in the hospital setting (12, 13). This asymmetry, which is also influenced by gender bias, obstructs the action of midwives and obstetric nurses. In this environment, the adoption of different care models by professionals gives rise to conflicts or interference in the care provided (12–15). Furthermore, the privileged power position of the professionals relative to the users affects the care provided and undermines women's autonomy (14–17), while the absence of connection between the health professionals and the pregnant woman can impact her choice of childbirth delivery (18, 19).

The form of health system organization, the legalization of hierarchical relationships, and the lack of financial, human, material, and managerial resources, coupled with a dearth of policies aimed at promoting respectful care, are elements that can contribute to the normalization and legalization of the mistreatment that women experience during delivery and childbirth. Throughout the world, this mistreatment has been shown to include physical, sexual, and verbal abuse; stigma and discrimination; and the adoption of inappropriate standards of care (12, 16, 19, 20).

The difficulties that stand in the way of adopting evidence-informed practices and a new childbirth care model are related in part to the absence of local protocols that spell out and safeguard these measures (14, 21). At the same time, the imposition of rigid protocols and/or standards can also hinder the provision of woman-centered care (12, 13, 17, 21, 22). For example, midwives may be required to meet hospital needs that interfere with the needs of the user. Also, the use of protocols may be seen by some midwives as a source of pressure and interference in the care they provide. Difficulty in establishing institutional measures that support practices based on the physiology of birth, respect users, and emphasize woman-centered care leads midwives and obstetric nurses to experience situations of psychological harassment, stress, and burnout (12, 13, 17, 22).

The hospital environment places high value on the use of technology, active management of childbirth, and strictly technical competencies (12, 13). In many places, women are forced to remain in prone position during childbirth, whether for cultural reasons or due to the inability of professionals to attend childbirth in other positions (16, 21, 23).

Human resources management

The difficulties related to human resources management are associated with the organizational levels of the workers and the health services and system in general. Professionals report excessive workloads with long days, no breaks, and many tasks to perform (12, 17, 20-22, 24–26). The shortage of professionals hinders the provision of adequate care (13, 16, 17, 20, 21, 27). These barriers are aggravated by hospital routines that press for faster care, affecting the perception of women in need of pain relief and their choices regarding the technologies used (16, 19–22).

The inadequate qualification of professionals (14–16, 18, 20, 21) and their low level of compensation (13, 15, 16, 20) can be barriers to accessing and adopting new practices. Inadequate education and training of professionals is associated with poor understanding of the rights of users (17, 18, 22) and lack of skill in receiving companions and including them throughout the process (16, 21, 28). In terms of the workplace, the safety measures that are adopted may focus on basic conditions for professionals and fail to consider the women (13, 16).

The barriers at the health system organizational level are related to the education of professionals. The omission of humanization in the academic curriculum (14, 22) and the lack of investment in the education and long-term recruitment of midwives and obstetric nurses and their ongoing presence in the services (13–15) can contribute to the continuity of inappropriate practices.

Knowledge and beliefs

The knowledge and beliefs of professionals and users can be barriers that impact the care provided during delivery and childbirth. Some women do not wish to receive medical treatment during delivery, which can affect their selection of where to give birth; others expect interventions, which may be understood by professionals as an indication of their passivity and acceptance of the medicalized care model (12, 16). Women may have difficulty accepting epidural analgesia for fear of the procedure and its risks (21); also, the selection of epidural analgesia as the first method of pain relief can limit the use of non-pharmacological methods (29).

In contexts where the sexual act is seen as sinful, health professionals may feel that abuse and the experience of pain during childbirth are due punishments for pregnant women (15, 21, 30). Differing views on childbirth mean that the use of technology is acceptable for some professionals, while for others only attendance and support are appropriate (12). In countries where episiotomy is freely practiced, there may be a belief that it facilitates childbirth (21, 25, 31, 32). Women's lack of knowledge of their rights also affects access to and the type of care they receive, as well as their selection of type of childbirth (15, 16, 18, 20).

TABLE 1. Synthesis of the findings on barriers to implementation of the recommendations, by thematic cluster, level of organization, category, and section of the *Guidelines*

Thematic cluster	Level	Category	Section of the *Guidelines*				
			General care during delivery	Where childbirth care is provided	Pain relief during delivery	Care during 1st stage of delivery	Care during 2nd stage of delivery
Care model	Services	Absence of local evidence-based protocols	••			••	••
		Absence of woman-centered care				••	
		Lack of institutional support for a new model of care	••••	••••			
		Imposition of the lithotomy position	•••		•••		
		Medicalization of care in the hospital setting		••	••		
		Hierarchical relationships in the work environment		••••			
	Systems	Abuse, disrespectful attitude, and mistreatment during childbirth	••••		••••		
		Biomedical model	••	••	••		
	Personnel	Lack of connection between health professionals and patients	••				
		Hierarchical relationship between health professionals and users	••••				
		Peer pressure regarding the model and type of care provided	•				
Human resources management	Services	Low remuneration of health professionals	••••	••••			
		Lack of preparation to receive the woman's companion	•••				
		Inadequate professional qualification	•••••				•••••
		Shortage of human resources	•••••••	•••••••		•••••••	
		Unsafe conditions for health professionals	••	••			
		Inadequate hospital routines	••••••		••••••	••••••	
		Excessive workload	••••••	••••••••	••••••••		
	Systems	Omission of the subject of humanization in the academic curricula	••				
		Lack of investment in the education and long-term recruitment of midwives and obstetric nurses in the services	•••	•••			
	Personnel	Reluctance of professionals to incorporate new practices and evidence		••			••
		Lack of understanding of users' rights	•••				
Knowledge and beliefs	Personnel	Beliefs and values of professionals			•••		•••
		Differing perceptions regarding normal childbirth	•				
	Users	Beliefs and values of women and/or companions regarding childbirth and/or procedures	•••		••••	••••	••••
		Desire to receive or not receive medical interventions	••	••			
		Difficulties faced by women regarding the use of epidural analgesia			•		
		Women's lack of knowledge about their rights	••••				
		Reluctance to use non-pharmacological methods to deal with pain			•	•	
Gender relations	Services	Men's attitudes based on gender stereotypes	••				
		Discrimination against women in managerial positions	•				
	Systems	Discrimination generated by unequal gender relations		•••			
	Personnel	Mistaken attitudes of health professionals regarding gender stereotypes					
	Users	Men's discomfort using the services	•	•			
		Presence or lack of preparation of fathers/companions during delivery	••				
		Discomfort of men in participating in activities	•				

(*Continued*)

TABLE 1. (Cont.)

Thematic cluster	Level	Category	Section of the *Guidelines*				
			General care during delivery	Where childbirth care is provided	Pain relief during delivery	Care during 1st stage of delivery	Care during 2nd stage of delivery
Health services management	Services	Lack of privacy	•••	•••			
		Insufficient material resources	••••••	••	••••••		
	Systems	Inadequate infrastructure		•••			
		Shortage of financial resources	•••				
		Lack of continuity between services	••	••			
Attitudes and behaviors	Personnel	Inappropriate attitudes and behaviors of health professionals		•••••	•••••	•••••	•••••
		Lack of willingness of health professionals to undergo training	•				
		Perceptions of health professionals regarding women's behavior	•				
		Fear of lawsuits	•				
Communication	Services	Absence or inefficiency of mechanisms for presenting complaints	•				
		Linguistic and interpretation barriers in communication between women and health professionals	••				
	Users	Linguistic and interpretation barriers in communication between women and health professionals	••				
	Personnel	Unsatisfactory communication between health professionals and women and/or companions		••••••	••••••	••••••	
Socioeconomic conditions	Users	Women's lower educational level	••				
		Women's lack of financial resources	••				
Political interests	Systems	Political interests	•				

•: Number of studies reporting the specific barrier.
Source: Own preparation based on the results of the present study.

Gender relations

In this thematic cluster, barriers related to attitudes of men and/or health professionals were found at all levels of organization. According to the studies analyzed, men may be unprepared to deal with childbirth and feel powerless and helpless with regard to the pain and suffering experienced by their partner. Some are reluctant to participate in awareness-raising activities about the rights of the women (33). The partners often feel uncomfortable using the health services, even when they are only accompanying the women (12). Despite health policies in place in some countries, such as Brazil, that encourage the participation of partners during gestation, childbirth, and the postpartum period, their health services still have difficulty inserting men in the process (31, 32). Also, for some women, the presence of their companion during childbirth can be a stressful factor (25, 28).

Gender stereotyping by professionals affects the care that women and their companions receive. Women who do not conform to standards and stereotypes of femininity may be mistreated, and women in managerial positions tend to be the subject of discrimination (15). Factors influenced by unequal gender relations include discrimination on the part of physicians toward midwives and obstetric nurses, as well as lack of incentive for these professionals to seek additional training and take autonomous action. Professional women experience work-related strain and receive lower pay. Care-giving, considered to be women's work, is less valued. For users, their lack of autonomy during childbirth and the violent acts they are subjected to during pregnancy, childbirth, and the puerperium also trace back to cultural gender bias (13, 15, 22).

Health services management

In the cluster relating to health services and systems management, shortages of medicines and other inputs are a barrier to the provision of adequate childbirth care (13, 16, 17, 20, 21, 29). Infrastructure problems can jeopardize the woman's privacy, while inadequate physical space can limit the presence of companions (16, 19, 21).

Infrastructure issues, such as inadequate sanitation and transportation, can hinder access to services (13, 21, 32). In terms of health system management, difficulties can arise due to lack of financial review, which can impact the hiring and retention of professionals and the upgrading of infrastructure (16, 20, 21). Challenges related to coordination and referrals between health services also affect the continuity of care (18, 19).

Attitudes and behaviors

The attitudes and behaviors of professionals toward women, including inappropriate conduct, negligence, and lack of compassion, can affect the care provided and the decisions that women make (16, 20, 21, 23, 26). Also, the failure of professionals to engage in trainings that are offered (24) and their fear of lawsuits may affect their practice (12).

Communication

Communication barriers between professionals, users, and their companions can result in women failing to receive adequate or needed information regarding their childbirth (16, 18, 20, 21, 24, 34). For example, the absence of interpreters (in the case of patients of other nationalities) and exclusion of family members and companions from the health units reinforce communication barriers (16, 19). In addition, the absence or inefficiency of mechanisms for filing claims or lawsuits means that violent situations are not adequately addressed (16).

Socioeconomic conditions

A woman's low educational level or lack of financial resources can negatively impact her access to care and the type of care she receives (15, 20).

Political interests

One of the challenges faced by the health system is the tendency of governments to coopt the interests of nongovernmental organizations involved in government initiatives. Also, partisan disputes within communities can affect girls' and women's awareness of their rights (17).

DISCUSSION

In the Brazilian context, the identification of barriers to complying with the recommendations in the Guidelines is an important step in the process of knowledge translation (7). The findings revealed the need for decision-makers and other social actors to become involved in considering strategies to change the current technocratic model, with special attention to communication challenges between users and professionals, management of human resources and health services, economic and sociocultural issues, gender violence, and political interests that stand in the way of more widespread adoption of good practices.

The difficulties reported by women in articulating their desires regarding their pregnancy and childbirth with health professionals, as well as in understanding the information given to them, were associated with the users' low levels of schooling. Also, maternal low level of schooling and low socioeconomic status are associated with reduced adherence to prenatal care and less participation in educational programs (35, 36). This reality means that the women end up with little knowledge about the physiology of delivery and childbirth or about their rights. Because it affects their expectations regarding the childbirth process and their perceptions of the care they receive, it constitutes an important barrier in the struggle against obstetric violence (37, 38).

Communication barriers between women and professionals can also be associated with the current health care model, where dialogue between women, families, professionals, and managers is virtually nonexistent (1). Is essential to look at the impact of gender bias on obstetric care, which can be seen in the difficulty of involving men in discussions about pregnancy and the childbirth process, in the mistreatment and abuse of pregnant women, in discrimination against women in managerial positions, and in the lack of incentive to train and hire midwives and obstetric nurses for prenatal, childbirth, and puerperium care.

Preliminary results reported by the Rede Cegonha (39) and the Appropriate Childbirth program show that the presence of a companion during vaginal childbirth has increased from 31.8% to 83.9% in the public sector and from 55.8% to 96.8% in the private sector. However, the data do not show whether the presence of the companions was the women's first choice, or how the companions were received in the units. Qualitative studies have shown that men have encountered difficulties in these situations, being denied permission to spend the entire time with the woman and being prevented from participating actively in supporting her (40, 41).

However, there have also been experiences in which fathers have been encouraged to participate in the delivery. These initiatives are important for promoting humanization of the health services and for deconstructing the type of masculinity that has a negative impact on the individual and his relationship with his partner, children, and society in general (42, 43). It is therefore essential to develop strategies that will guarantee all women the right to have their companion present during childbirth, sensitize professionals and users, make financial resources available, and secure the commitment of managers (44). For in fact, studies showed that presence of a companion leads to women's increased satisfaction with the childbirth process and the adoption of better care practices on the part of professionals (41, 45).

The World Health Organization (WHO) recognizes that disrespect toward women in childbirth is a global public health problem. Furthermore, it claims that the problem stems from a foundation of gender stereotypes inherent in the education of health professionals and the organization of health services (46). Seen through this lens, a woman's body is considered imperfect and also a risk factor because it needs to be attuned and cared for, culminating in the devaluation of women's sexuality through authoritarian, discriminatory, and iatrogenic attitudes on the part of professionals (11).

Another reality in Brazil is the difficulty introducing other actors and ensuring that they stay involved in childbirth care, something that is deeply influenced by gender bias. The number of obstetric nurses in the country is unknown, but the perception is that there are few and that they are often assigned to non-obstetric areas (47). In 2008, only 8% of normal deliveries were attended by obstetric nurses (48). Thanks to incentivization by the Rede Cegonha campaign, this percentage increased to 27% in the public sector, though the practice remained virtually nonexistent in the private sector (1.8% in 2017) (39). To facilitate graduate education in physiologic birth for professional specialists and increase the supply of midwives in the health services, the University of São Paulo (USP) reinstated its degree program in obstetrics in 2005 (49). However, midwives continue to face challenges to becoming fully active and incorporated in the health services, despite experiences confirming the positive impact of their participation in delivery and childbirth care (47, 50).

The limited number of health workers creates an excessive workload and the problem is aggravated by low wages and unacceptable schedules (50-52). There are also weaknesses in the process of educating and updating professionals. A qualitative study that assessed barriers and facilitators in hospitals of Latin America showed that the reluctance of professionals to change

their practices starts with the university curriculum, since they were not trained to see that knowledge is always changing in the field of medicine. Furthermore, they fail to develop sufficient skills to understand the scientific literature (53). To achieve fully skilled obstetric practice, the education of health professionals will need to include discussions about the humanization of childbirth, gender, and the rights of women (46, 54).

Finally, it will not be possible to overcome the barriers identified without proper health services management. Areas that should be examined in the services include infrastructure, adequate professional staffing, basic sanitation, transportation, and resources or budgetary funding.

Limitations of the study

It should be kept in mind that this rapid review used methodological shortcuts that were defined in advance and thoroughly considered by the authors—for example, limitation of the searches and the selection and extraction of articles by a single reviewer. A few important limitations should be kept in mind in interpreting the results. First, the decision to limit the number of databases reviewed was based on the time available to complete the study. Thus, the impact of the coverage of this review should be considered in interpreting the results presented. Second, only secondary studies and clinical practice guidelines were included, which may have resulted in barriers not being identified for several of the recommendations in the Guidelines. Although the confidence level for the evidence in the narrative reviews is lower, they address barriers that appear to be relevant to the Brazilian context, since all are national reports. Third, quality was only assessed for the systematic reviews. Although these reviews represent a large proportion of the included studies, the reliability of the results presented in the remaining types of studies, such as the narrative reviews, is less certain and caution is advised in interpreting them. Finally, the absence of barriers associated with care in the third stage of delivery, maternal care immediately following childbirth, and newborn care may mean that more specific search terms for these stages of care should have been included.

Final considerations

The findings from this rapid review shed light on a problem that is neither new nor unknown. By clearly visualizing barriers to implementation of the Guidelines, we can ensure that the strategies adopted to overcome them are based on solid evidence, clearly delineated, and agreed upon with the actors involved. Childbirth care is clearly complex, and the focus is on promoting natural childbirth, which has been challenged for many years by the medicalized approach to obstetric care in Brazil and throughout the world.

Eliminating the identified barriers to implementation can lead to good care practices, reduce the high rates of unnecessary C-sections and avoidable maternal and neonatal deaths, and help reclaim the transformative potential of the childbirth experience for women, children, and society. Joint action may be necessary to promote ways to raise the financial and educational status of women and families, improve mechanisms for managing health professionals and facilities, and raise awareness to combat gender inequities and the violent acts that stem from them.

Effective implementation of the Guidelines and construction of a model centered on the needs of each woman and family will require a commitment by managers and professionals to embrace good care practices, as well as assurance that health strategies and policies based on incentivization and monitoring, such as the Rede Cegonha, will continue to be supported. Finally, the identified socioeconomic barriers underscore the need for a more just and welcoming society—one that promotes the autonomy of individuals and full respect for them from the moment they are born.

Authors' contributions. JOMB and EMGC conceived the study. CFO, AAVR, and MCB performed the search, extraction, synthesis, and interpretation of the data and wrote the first draft of the manuscript. CDLJ also participated in the interpretation of the data. TST also participated in the search and interpretation of the data. All the authors contributed to, reviewed, and approved the final version of the manuscript.

Conflicts of interest. JOMB receives remuneration from the Oswaldo Cruz Foundation (Fiocruz); TST and MCB receive remuneration from the São Paulo Health Institute. CFO, AAVR, and CDLJ received a research fellowship. The authors declare that they have no conflicts of interest that may have affected the management of the study or the presentation of the results.

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Obstáculos a la aplicación de las recomendaciones para la atención del parto normal: revisión rápida de evidencia

RESUMEN

Objetivo. Identificar los posibles obstáculos a la aplicación de las recomendaciones formuladas en las Directrices Nacionales para la Atención del Parto Normal en Brasil a partir de la mejor evidencia disponible a nivel mundial.

Métodos. Entre marzo y abril de 2019 se llevó a cabo una revisión rápida de seis bases de datos. Se seleccionaron estudios secundarios publicados en español, inglés o portugués sobre los obstáculos de cualquier tipo que pudieran estar relacionados con la aplicación de las recomendaciones contenidas en las Directrices.

Resultados. Se incluyeron 23 documentos (21 revisiones sistemáticas y 2 guías de práctica clínica). Los obs- táculos identificados se agruparon en 52 categorías con base en su semejanza de significado y luego se reorganizaron en nueve grupos temáticos: modelo de atención del parto, gestión de recursos humanos, creencias y conocimientos, relaciones de género, gestión de servicios de salud, actitudes y comportamientos, comunicación, condiciones socioeconómicas e intereses políticos.

Conclusiones. La aplicación de las Directrices puede requerir enfoques combinados para hacer frente a diferentes obstáculos. La participación de los administradores y los trabajadores de la salud en el proceso de cambio del modelo de atención del parto, así como la participación de los usuarios, son fundamentales para que la aplicación de las Directrices sea satisfactoria. Además, se necesitan medidas intersectoriales para mejorar las condiciones socioeconómicas de las mujeres y las familias y para combatir las desigualdades entre los géneros.

Palabras clave Política informada por la evidencia; ciencia de la implementación; guías de práctica clínica como asunto; parto; Brasil.

Barreiras à implementação de recomendações para assistência ao parto normal: revisão rápida de evidências

RESUMO

Objetivo. Identificar potenciais barreiras à implementação das recomendações das Diretrizes Nacionais de Assistência ao Parto Normal a partir das melhores evidências globais disponíveis.
Métodos. Realizou-se uma revisão rápida com consulta a seis bases de dados em março/abril de 2019. Foram selecionados estudos secundários publicados em inglês, espanhol ou português sobre barreiras de qualquer natureza que pudessem ser relacionadas à implementação das recomendações das Diretrizes.
Resultados. Foram incluídos 23 documentos (21 revisões sistemáticas e dois guias de prática clínica). As barreiras identificadas foram agrupadas em 52 categorias por semelhança de significado e, em seguida, reorganizadas em nove núcleos temáticos: modelo de atenção ao parto e nascimento, gestão de recursos humanos, crenças e saberes, relações de gênero, gestão de serviços de saúde, atitudes e comportamentos, comunicação, condições socioeconômicas e interesses políticos.
Conclusões. Os resultados mostraram que a implementação das Diretrizes pode requerer abordagens combinadas para o enfrentamento de diferentes barreiras. O engajamento de gestores e profissionais de saúde no processo de mudança do modelo de atenção ao parto e nascimento e o envolvimento de usuários são indispensáveis para o sucesso da implementação. São necessárias, ainda, ações intersetoriais para melhorar as condições socioeconômicas de mulheres e famílias e para combater as iniquidades de gênero.

Palavras-chave Políticas informadas por evidências; ciência da implementação; guias de prática clínica como assunto; parto; Brasil.