

## Movements toward change in women's health care in teaching hospitals in Brazil

### *Movimentos de mudança no cuidado em saúde das mulheres em hospitais de ensino no Brasil*

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**ABSTRACT** This study aims to analyze the primary outcomes of the ApiceON Project within its care component, highlighting its developments and impacts. This descriptive study is based on secondary data produced from 2017 to 2020 during the project's implementation in 96 teaching hospitals distributed across all Brazilian regions. We analyzed the strategic indicators and evaluation items related to the care component, focusing on temporal trends across the project's thematic axes. The results indicate advances in childbirth and newborn care, with a reduction in the proportion of items classified as 'nonexistent' and an increase in those labeled 'advanced', reflecting the incorporation and expansion of best practices. Improvements in best practices for care and Health Conditions Surveillance were particularly notable in hospitals located in the Northeast and Midwest. We observed an increase in the percentage of hospitals with obstetric nurses providing care, the use of immediate postpartum intrauterine devices, and childbirths attended by a companion. The project revealed the capacity to drive change in health services, promoting the qualification of obstetric and neonatal care and contributing to the development of practices grounded in reproductive rights and the safety of care for women and newborns.

**KEYWORDS** Hospitals, maternity. Hospitals, teaching. Quality of health care. Maternal-child health services. Obstetrics.

**RESUMO** Este estudo tem como objetivo analisar os principais resultados do Projeto ApiceON quanto ao componente 'Atenção', destacando seus acúmulos e repercussões. Trata-se de um estudo descritivo, baseado em dados secundários produzidos de 2017 a 2020, durante a execução do projeto em 96 hospitais de ensino distribuídos por todas as regiões do Brasil. Analisaram-se indicadores estratégicos e itens avaliativos relacionados ao componente Atenção, com foco na evolução temporal nos eixos temáticos do projeto. Os resultados evidenciam avanços na atenção ao parto e nascimento, com redução da proporção de itens 'inexistentes' e ampliação dos classificados como 'avançados', refletindo na incorporação e expansão de boas práticas. Houve destaque para melhorias nas Boas Práticas de Atenção e Vigilância de Condições de Saúde, especialmente nos hospitais das regiões Nordeste e Centro-Oeste. Houve, também, incremento no percentual de hospitais com enfermeiras obstétricas na assistência, inserção de dispositivos intrauterinos pós-parto imediato e realização de partos com presença de acompanhante. O Projeto demonstrou capacidade de induzir mudanças nos serviços de saúde, promovendo a qualificação do cuidado obstétrico e neonatal e contribuindo para a construção de práticas baseadas em direitos reprodutivos e segurança do cuidado à mulher e ao recém-nascido.

**PALAVRAS-CHAVE** Maternidades. Hospitais de ensino. Qualidade da assistência à saúde. Centros de saúde materno-infantil. Obstetrícia.

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## Introduction

Women's health care has been widely debated in academia and global policies and is a central focus in guaranteeing human rights<sup>1</sup>. The struggle for the realization of sexual and reproductive rights has become a historic agenda for feminist and social movements, facing normative, institutional, and cultural resistance<sup>2,3</sup>.

In Brazil, the affirmation of women's health and rights in recent decades has been associated with both cross-cutting policies such as the National Humanization Policy (PNH) and specific policies such as the National Policy for Comprehensive Women's Health Care, the Rede Cegonha, and, more recently, the Alyne Network<sup>4,5</sup>. These initiatives aim to reorient a model historically marked by technocracy and the medicalized female body<sup>6</sup>.

In this context, it is necessary to break with the logic that reduces women to objects subject to fragmented technical interventions, recognizing them as active subjects in the production of their own care<sup>7</sup>. This situation implies shifting the exclusive emphasis on biomedical intervention to a perspective that values their experiences and knowledge, working with women in living networks of knowledge, practices, and affections that expand territories of care<sup>8,9</sup>.

The commitment to the leadership of diverse groups represents resistance to the silencing imposed by hegemonic models, shaped by a patriarchal logic that historically disregards women's bodies and experiences<sup>9</sup>. Denaturalizing this model requires problematizing social norms that legitimize interventionist practices and reproduce intersectional gender oppressions, which, combined with factors such as race, class, and generation, perpetuate structural inequalities in care<sup>10-12</sup>.

In this sense, the PNH proposes recognizing and including subjects, groups, and conflicts, (trans)forming health services into territories of care that serve both those

who are cared for and those who provide care<sup>13</sup>. This expanded concept of care has influenced policies to transform health practices, promoting changes in practice, autonomy, and collective spaces for analysis and decision-making<sup>13</sup>. Inspired by the PNH ethical and methodological principles, the Rede Cegonha was launched in 2011 as a response to the challenge of transforming the Brazilian obstetric-neonatal care model<sup>6</sup>.

This initiative challenged the instituted management methods, processes, and care practices, not limited to the pursuit of greater effectiveness in care and management, but also incorporated its own way of doing politics and intervening in the Health sector<sup>14</sup>. Its guidelines encompass both the ethical dimension of care and service provision, as well as the reorganization of practices, work processes, and care flows, to expand access to and improve the quality of care<sup>6</sup>.

Among the Rede Cegonha's strategies, the ApiceON Project stands out, a national initiative that used teaching hospitals as a strategic platform to promote changes in care, education, and management models focused on women's and children's health. The project's premises were transforming women's care, including pregnancy, childbirth, and sexual and reproductive health; providing care to abortion and situations of violence; and expanding education-service integration to improve care practices and professional training within the Unified Health System (SUS)<sup>15,16</sup>.

Based on the concept of transversality and collective work analyses, the implementation of ApiceON aimed to expand and improve care, training, and management practices. It was an institutional intervention to transform women's care fields, mobilizing methodological contributions that favored incorporating best practices and improving multidisciplinary teams<sup>16</sup>.

We propose a critical and coordinated analysis of the advances and challenges, as well as strategies for the sustainability of the actions

developed in all the participating hospitals, with a focus on the care component. Therefore, this study aims to analyze the main results of ApiceON in this component, highlighting its accumulations, repercussions, and interfaces with the transformation of the care model.

## Material and methods

This descriptive study is based on secondary data from the multicenter ApiceON project, sponsored by the Ministry of Health and led by the Federal University of Minas Gerais (UFMG), which involved 96 teaching hospitals affiliated with the Unified Health System (SUS) nationwide. The hospitals eligible for the sample performed more than 1,000 births in 2015, according to the Hospital Information System<sup>14</sup>. Implementation was based on institutional support and share management<sup>17</sup>, leveraging agreed-upon arrangements and actions through methodological tools and continuous evaluation. The project considered institutional contexts as its analytical basis and was organized into three components structured into guidelines, dimensions, and evaluation items<sup>14</sup>.

This study focuses on the care component, subdivided into four guidelines: (i) Reception: connection between professionals and users, respect for cultural, ethnic-racial diversity, attention to vulnerable populations and adoption of reception with obstetric risk classification; (ii) Good Practices: promotion of evidence-based practices, reduction of unnecessary interventions, insertion of obstetric nurses and midwives, providing abortion and sexual violence care; (iii) Surveillance: monitoring of indications for cesarean section, maternal and neonatal morbidity and mortality and patient safety; and (iv) Ambiance: adequacy of physical and organizational spaces, including the obstetric center and the neonatal unit<sup>14</sup>.

We should emphasize that the term best practices refers to actions or interventions that have shown positive effects in the specific context of the participating hospitals. Therefore, these are not fixed or universally replicable models, but rather contextualized practices developed in dialogue with local realities<sup>8</sup>.

During the intervention, a transversal assessment was adopted following all stages of the project's execution. To operationalize this method, a local strategic group was established in each hospital to coordinate professionals, managers, and faculty in monitoring the actions and implementing the proposed changes<sup>14</sup>.

Planning, monitoring, and evaluation tools were used, such as Situational Diagnoses (SD) and the Strategic Indicators Dashboard (SID), which were collectively discussed with local teams. The SD captured the status of services and was periodically reassessed. This study considered the first SD of 2017 and the last one of August 2020<sup>14</sup>.

Using a structured and quantitative approach, services were evaluated across different dimensions based on indicators that assigned a 'grade' to each area's stage of development. The assessment classified the situation as follows: 'Nonexistent': dimensions not yet implemented; 'Incipient': requiring substantial effort; 'Intermediate': minor adjustments; and 'Advanced': no need for priority improvement<sup>14</sup>.

Hospitals updated SID data directly on a virtual platform. Six evaluation items were prioritized, not only for their thematic relevance, but also because they constitute strategic drivers of care model transformation. These items are: the availability of obstetric nurses and midwives during low-risk births; immediate insertion of an intrauterine device (IUD) postpartum and post-abortion; legal termination of pregnancy services; provision of manual intrauterine vacuum aspiration (MIVA) post-abortion; and care for victims of sexual violence<sup>16</sup>.

For analysis, the data were coded in double entry and analyzed in the SPSS<sup>18</sup> (v.20) and R<sup>19</sup> (v.3.4.1) software. They were presented using absolute frequencies and percentages. The UFMG Research Ethics Committee approved the study under Opinion N° 7.051.498, in accordance with Resolution N° 466/1220 of the National Health Council (CNS). The current version is an amendment to the original project. The analysis was conducted by geographic region, ensuring confidentiality and anonymity of the hospitals.

## Results

The project involved 96 teaching hospitals distributed across all federal states: 13 in the North; 17 in the Northeast; 13 in the Midwest; 16 in the Southeast (Espírito Santo, Minas Gerais, and Rio de Janeiro); 20 in the Southeast (São Paulo); and 17 in the South. Due to the significant number of services, the state of São Paulo was treated as its own macroregion. *Table 1* contains some characteristics of these services.

Table 1. Distribution and structural characteristics of hospitals participating in the ApiceON project by region and in Brazil (2017)

Variables	Midwest		Northeast		North		Southeast 1		Southeast 2		South		Brazil	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
<b>Location</b>														
Capital	12	92.3	16	94.1	12	92.3	11	68.8	11	55	12	70.6	74	77.1
Inland region	1	7.7	1	5.9	1	7.7	5	31.3	9	45	5	29.4	22	22.9
<b>Administration</b>														
Municipal	1	7.7	1	5.9	2	15.4	2	12.5	1	5	1	5.9	8	8.3
State	6	46.2	7	41.2	9	69.2	3	18.8	13	65	2	11.8	39	40.6
Federal	6	46.2	7	41.2	2	15.4	6	37.5	2	10	10	58.8	33	34.4
Private	0	0	2	11.8	0	0	5	31.3	4	20	4	23.5	14	14.6
<b>Qualification</b>														
Teaching Hospitals	6	46.2	9	52.9	2	15.4	11	68.8	18	90	10	58.8	56	58.3
University Hospital	5	38.5	6	35.3		0	5	31.3	2	10	7	41.2	25	26
Teaching Auxiliary Unit	2	15.4	2	11.8	11	84.6	0	0	0	0	0	0	15	15.6
<b>Number of births</b>														
1,000-2,000	7	53.8	2	11.8	1	7.7	6	37.5	8	40	7	41.2	31	32.3
2,000-4,000	5	38.5	8	47.1	4	30.8	8	50	9	45	8	47.1	42	43.8
More than 4,000	1	7.7	7	41.2	8	61.5	2	12.5	3	15	2	11.8	23	24

Source: Prepared by the authors.

Regarding hospital performance, an improvement was observed in the care component. Nationally, items classified as 'nonexistent' decreased from 23.3% to 15.8% (-7.4 percentage points), and those classified

as 'advanced' increased from 25.3% to 32.0% (+6.7 percentage points).

Among the regions, the most considerable reductions in 'nonexistent' items occurred in the Northeast (from 19.3% to 11.3%, -70.0%),

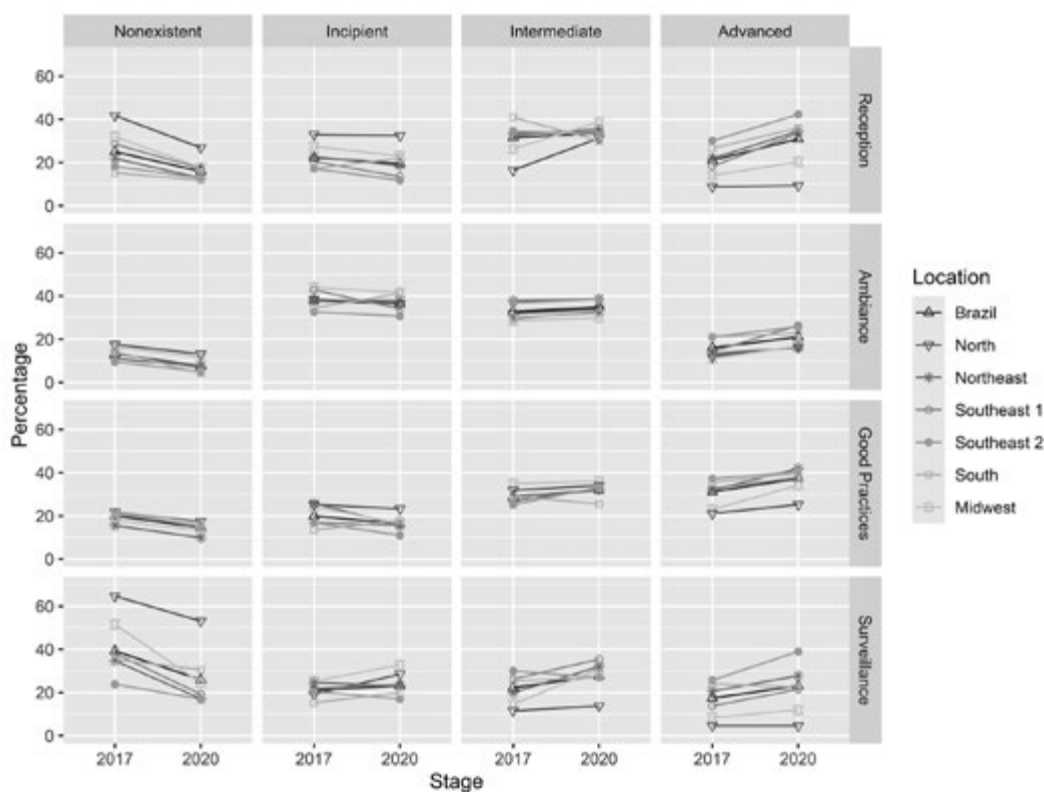
Midwest (from 25.8% to 15.7%, -64.3%) and Southeast 1 (from 24.8% to 15.2%, -63.1%), with a concomitant increase in 'advanced' items: Northeast, from 26.1% to 35.4% (+26.4%); Midwest, from 17.6% to 26.0% (+32.3%); Southeast 1, from 24.9% to 33.4% (+25.5%).

Minor variations were observed in the other regions. In Southeast 2, 'nonexistent' items fell from 19.5% to 13.9% (-39.2%) and 'advanced' items rose from 32.2% to 38.9% (+17.3%). In the North, 'nonexistent' items declined from 32% to 24.3% (-31.6%) and 'advanced' items increased from 15% to 17% (+15.7%). In the

South, 'nonexistent' items dropped from 21.8% to 16.5% (-32.2%) and 'advanced' items grew from 30.3% to 34.5% (+12.1%).

Graph 1 shows hospital performance across the guidelines that comprise the care component, highlighting regional variations and overall results. The results show a downward trend in the 'Nonexistent' stage and an increase in the 'Advanced' stage across all guidelines, reflecting progress in improving practices, although some regions and guidelines performed better than others.

Graph 1. Performance in the guidelines of the care component of hospitals participating in the ApiceON project by region and in Brazil (2017-2020)



Source: Prepared by the authors.

The Good Care Practices guideline showed the most significant progress, with a 6.1% increase in the 'advanced' stage, from 31.1% in 2017 to 37.2% in 2020, and a 5.4% decrease in

the 'nonexistent' stage, from 20.0% to 14.6% over the same period. Health Conditions Surveillance also performed well, with a 5.7% increase in the 'advanced' stage, from 17.4%

in 2017 to 23.1% in 2020, and a considerable 13.3% decrease in the ‘nonexistent’ stage, from 39.3% to 26.0%.

The Reception guideline registered a 4.9% increase in the ‘advanced’ stage, from 16.1% in 2017 to 21.0% in 2020, and a 5.8% decrease in the ‘nonexistent’ stage, from 13.3% to 7.5%. In turn, Ambiance displayed the smallest growth in the ‘advanced’ stage, with an increase of 5.9% (from 11.0% in 2017 to 16.9% in 2020), although it also registered a 4.8% decrease in the ‘nonexistent’ stage (from 16.5% to 11.7%).

Among the regions, the Northeast stood out with significant increases in the ‘advanced’ stage in Good Care Practices (10.1%), from 31.9% in 2017 to 41.9% in 2020, and in Health Conditions Surveillance (7.2%), from 20.6% to 27.8%. Furthermore, it showed a substantial reduction in the ‘nonexistent’ stage, especially in Health Conditions Surveillance, from 34.7%

in 2017 to 17.2% in 2020. The Midwest region saw a similar growth, with a 3.4% increase in the ‘advanced’ stage for Health Conditions Surveillance, from 8.5% to 11.8%, and a 27% decrease in the ‘nonexistent’ stage, from 51.5% to 24.5%. Southeast 1 also achieved good results, with a 12.1% increase in Ambiance, from 14.3% to 26.4%, and a 6.8% decrease in the ‘nonexistent’ stage, from 13.4% to 6.6%, standing out for its consistent improvements. The South region saw a 4.3% increase in Good Care Practices, from 35.5% to 39.8%, and a 5.3% decrease in the ‘nonexistent’ stage, from 22.1% to 16.8%.

Table 2 contains the performance of hospitals in the six strategic monitoring assessment items, explaining the number and percentage of services that offered such actions throughout the analyzed period, according to collected data.

Table 2. Strategic monitoring indicators related to care for women during childbirth, sexual and reproductive health, and situations of violence. Brazil and regions. 2017-2020

Region (n)	Year	Obstetric	Postpartum	Sexual violence	Legal	Manual	Post-abortion
		nursing in childbirth care	IUD insertion	care service	termination of pregnancy service	Intrauterine Vacuum Aspiration	
		n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Brazil (96)	2017	66 (68.9%)	39 (40.6%)	70 (72.9%)	67 (69.8%)	87 (90.6%)	31 (32.3%)
	2018	72 (75%)	69 (71.9%)	69 (71.9%)	67 (69.8%)	86 (89.6%)	58 (60.4%)
	2019	75 (78.1%)	73 (76%)	61 (63.5%)	52 (54.2%)	64 (66.7%)	65 (67.7%)
	2020	73 (76%)	73 (79.3%)	62 (64.6%)	53 (57.6%)	67 (72.8%)	58 (60.4%)
North (13)	2017	11 (84.6%)	2 (15.4%)	11 (84.6%)	9 (69.2%)	11 (84.6%)	2 (15.4%)
	2018	12 (92.3%)	5 (38.5%)	10 (76.9%)	9 (69.2%)	11 (84.6%)	4 (30.8%)
	2019	8 (61.5%)	9 (69.2%)	7 (53.8%)	10 (76.9%)	8 (61.5%)	9 (69.2%)
	2020	8 (61.5%)	9 (75%)	7 (58.3%)	8 (61.5%)	9 (69.2%)	9 (69.2%)
North- east (17)	2017	16 (94.1%)	8 (47.1%)	12 (70.6%)	17 (100%)	17 (100%)	6 (35.3%)
	2018	17 (100%)	14 (82.4%)	13 (76.5%)	17 (100%)	16 (94.1%)	9 (52.9%)
	2019	17 (100%)	15 (88.2%)	12 (70.6%)	13 (76.5%)	13 (76.5%)	13 (76.5%)
	2020	17 (100%)	15 (88.2%)	12 (70.6%)	13 (76.5%)	13 (76.5%)	10 (58.8%)

Table 2. Strategic monitoring indicators related to care for women during childbirth, sexual and reproductive health, and situations of violence. Brazil and regions. 2017-2020

Region (n)	Year	Obstetric	Postpartum	Sexual violence	Legal	Manual	
		nursing in childbirth care	IUD insertion	care service	termination of pregnancy service	Intrauterine Vacuum Aspiration	Post-abortion IUD insertion
		n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Midwest (13)	2017	10 (76.9%)	7 (53.8%)	10 (76.9%)	8 (61.5%)	11 (84.6%)	7 (53.8%)
	2018	10 (76.9%)	10 (76.9%)	8 (61.5%)	7 (53.8%)	11 (84.6%)	9 (69.2%)
	2019	12 (92.3%)	13 (100%)	10 (76.9%)	7 (53.8%)	11 (84.6%)	11 (84.6%)
	2020	12 (92.3%)	13 (100%)	10 (76.9%)	7 (53.8%)	7 (53.8%)	10 (76.9%)
South- east 1 (16)	2017	12 (75%)	4 (25%)	10 (62.5%)	12 (75%)	16 (100%)	2 (12.5%)
	2018	12 (75%)	14 (87.5%)	10 (62.5%)	11 (68.8%)	14 (87.5%)	13 (81.3%)
	2019	12 (75%)	13 (81.3%)	10 (62.5%)	13 (81.3%)	12 (75%)	11 (68.8%)
	2020	10 (62.5%)	13 (81.3%)	11 (68.8%)	11 (68.8%)	12 (75%)	11 (68.8%)
South- east 2 (20)	2017	8 (40%)	12 (60%)	16 (80%)	10 (50%)	18 (90%)	9 (45%)
	2018	12 (60%)	16 (80%)	16 (80%)	10 (50%)	18 (90%)	13 (65%)
	2019	15 (75%)	13 (65%)	11 (55%)	12 (60%)	10 (50%)	11 (55%)
	2020	15 (75%)	14 (70%)	11 (55%)	5 (25%)	5 (25%)	10 (50%)
South (17)	2017	9 (52.9%)	6 (35.3%)	11 (64.7%)	11 (64.7%)	14 (82.4%)	5 (29.4%)
	2018	9 (52.9%)	10 (58.8%)	12 (70.6%)	11 (64.7%)	16 (94.1%)	10 (58.8%)
	2019	11 (64.7%)	10 (58.8%)	11 (64.7%)	10 (58.8%)	9 (52.9%)	10 (58.8%)
	2020	11 (64.7%)	9 (52.9%)	11 (64.7%)	8 (47.1%)	8 (47.1%)	8 (47.1%)

Source: Prepared by the authors.

The number of hospitals with nurse-midwives and midwives assisting with childbirth increased from 68.9% in 2017 to 79.3% in 2020. The Northeast region, which already had the highest proportion of hospitals classified as 'advanced' in this regard at the beginning of the project, achieved full coverage starting in 2018 and maintained this level until the end of the period. The Midwest and North also saw growth, reaching 92.3% coverage.

Regarding IUD insertion postpartum, the national average hiked from 40.6% to 79.3%. The Midwest started at 53.8% and reached full coverage in 2019, keeping this rate until 2020. In the North, coverage grew from 15.4% in 2017 to 75.0% in 2020, remaining below the national average.

IUD insertion coverage after abortion increased from 32.3% in 2017 to 63.0% in 2020, emphasizing the North, which grew from 15.4% to 75.0% between 2017 and 2020; the South and Southeast 2 rose, respectively, from 29.4% to 83.3% and from 45% to 50%. In contrast, realizing the MIVA decreased from 90.6% to 72.8%, with the most considerable reduction in the Southeast 2, from 90% to 25%, and the Midwest, from 84.6% to 53.8%.

The provision of legal termination of pregnancy services also declined nationally, from 69.8% to 57.6%, with drops in the Southeast 2, from 50% to 25%, and the Northeast, which had full coverage in the first years and dropped in the last two, reaching 76.5% in 2020. Similarly, the number of hospitals that offered services to victims of sexual violence

fell from 72.9% to 67.4%, more sharply in the North, from 84.6% to 58.3%, and in the Southeast 2, from 80% to 55%.

Regionally, the Northeast achieved the best results, achieving full coverage of postpartum IUDs and legal termination of pregnancy in the first years of the project. The Midwest also excelled in expanding postpartum and post-abortion IUD coverage. Conversely, the Southeast 2 experienced significant declines, especially in MIVA procedures and the provision of legal termination of pregnancy. The North, although it made progress in some indicators, remained below the national average, particularly in sexual violence and legal abortion care.

## Discussion

The results highlight progress in implementing so-called best practices in ApiceON participating hospitals, including the incorporation of previously nonexistent items and the expansion of Good Care Practices at a consolidated level. These advances reflect changes in hospital practices, driven by technological, logistical, and organizational mobilizations, which led teams to incorporate innovations and improve their work practices.

The data reveal heterogeneity among the participating hospitals, with variations in structural and administrative aspects directly influencing each hospital's performance during project implementation. The varying service characteristics, such as available resources and regional contexts, resulted in distinct challenges and opportunities for improvement.

Before evaluating performance, we stress that the indicators in this study are considered as analyzers – that is, not merely quantitative measures, but as elements that reveal challenges, transformations, institutional forces, and the singularities of institutional processes and relationships. Based on Lourau's concept of analyzers<sup>21</sup>, it is considered that the indicators should be interpreted within the specific

context of ApiceON and its participating services. The evaluation was not limited to monitoring, but instead operated as a device that mobilized reflection and guided the renewal of institutional practices<sup>14</sup>.

The relevance of this approach is confirmed by the services' own trajectory throughout the project, as revealed by data related to the use of evaluation items. Mendes and Rattner<sup>22</sup> argue that, at the beginning of the project's implementation, approximately 30% of hospitals did not collect data regarding their actions and practices for the proposed items. As the project progressed, a progressive increase in the input and updating of evaluation items was observed. By the end of the intervention, all services began collecting and consolidating indicators, showing the incorporation of monitoring and evaluation into services.

The Health Conditions Surveillance guideline began the project with the highest proportion of assessments classified as 'non-existent'. That may be why it showed the most significant positive variation over time. The progressive incorporation of assessment item monitoring into the service routine began to play a mobilizing role by operating a collective work analysis mechanism, in which managers and professionals began to share data analysis, identify priorities, define action plans, and formulate intervention mechanisms.

Assis et al.<sup>23</sup> emphasize that this incorporation into the routine of services plays a central role as one of the project's effects. This process did not occur linearly, but rather through complex movements, marked by advances and retreats, which defy simplistic analyses based on notions of 'greater or lesser adherence' or 'greater or lesser resistance'. Instead, the consolidation of this practice reflects the services' ability to overcome barriers and integrate the monitoring of assessment items as an essential part of management and care for women. This movement introduced a systematic planning, monitoring, and evaluation approach to teams, resulting in changes to care processes and the impact the project achieved.

Thus, the use of assessment items exceeded a traditional evaluative function, gradually becoming a management tool in the daily routine of services. It contributed to the materialization of shared management principles, understood here as a democratic mode of institutional organization based on dialogue, active participation, and continuous negotiation among the subjects involved in the care and management processes<sup>24</sup>.

Despite these advances, not all guidelines have evolved to the same degree of implementation. The *ambiance* guideline, aimed at adapting hospital spaces to make them more receptive and encourage active user participation<sup>25</sup>, showed the least progress, especially in the proportion of hospitals with 'advanced' status.

However, we observed that part of the decline in 'nonexistent' cases migrated to 'incipient' status. This movement suggests the need for greater efforts to implement the *ambiance* model in services, which is corroborated by Pasche et al.<sup>25</sup>, who highlight the urgency of initiatives to transition the *ambiance* model, even in the face of persistent structural challenges. These authors also associate this situation with the historical SUS underfunding, which compromises the implementation of renovations in the physical spaces of maternity wards.

Reception, understood as a broad guideline, involves an ethical approach based on inclusion and respect for differences, embodied by relational technologies such as qualified listening, guaranteed access, bonding, and attention to the needs of women and their families. In addition to adopting the obstetric risk classification protocol, its implementation requires coordination with the local SUS network to ensure the connection of pregnant women to health facilities and establish safe transfer flows<sup>14</sup>.

The best performance occurred in the incorporation of Good Care Practices during labor and birth. Humanized, evidence-based care was introduced or expanded, replacing

unnecessary or harmful practices, with adaptations tailored to the context and pace of each location. However, this incorporation was neither linear nor free from resistance, especially in highly hierarchical settings that support traditional models<sup>25</sup>.

This type of challenge also manifests itself in professional training processes, especially in Medicine and Nursing residency programs. Carvalho et al.<sup>26</sup>, when analyzing Nursing and Obstetrics residencies, observed that Nursing incorporated scientific content and humanized practices into theoretical and clinical teaching. At the same time, medical education did not explicitly address such guidelines. The study also revealed the persistence of unnecessary practices in both programs, reinforcing the relevance of ApiceON in strengthening the care component and inducing educational changes.

Such resistance is also evident in the field of training and more broadly expresses the organizational logic that tends to preserve historically established models. Pasche et al.<sup>25</sup> highlight the resistance to change on the part of health service managers and teams. The authors argue that there is a tendency to preserve what has been institutionalized in the organization. Resistance functions as an analyzer, revealing tensions between the established and the dynamics of change and helping to expose the logic that underpins professional practices<sup>27</sup>.

In more rigid contexts, such as hospitals, where power relations are more unequal, forces are focused on conservation<sup>25</sup>. This reality perpetuates situations such as the continuation of unnecessary interventions to the detriment of proven beneficial practices. These aspects show the challenge faced by ApiceON, which, even in this context, managed to drive change on several fronts.

The evaluation items were organized into the thematic axes of ApiceON: change in the care model with the inclusion of nursing, represented by the indicator Obstetric Nursing in childbirth care; access to reproductive planning with postpartum IUD insertion;

humanized care for legal abortion, with indicators on pregnancy termination, post-abortion IUD, and MIVA; and care for women in situations of sexual violence<sup>15</sup>.

Although the role of obstetric nurses in assisting women during labor and birth is recognized<sup>28</sup>, there were few opportunities for their integration into these services, and several factors still hinder their professional practice. Mendes and Rattner<sup>22</sup> identified a shortage of obstetric nurses in these hospitals, who represent only 1% of the total staff. Furthermore, the proportion of births attended by obstetric nurses exceeded 50% of vaginal births in only six hospitals, while this percentage was between 15% and 50% in eight other hospitals. In this regard, the Northeast stood out, reaching 100% of services since 2018.

The immediate insertion of the postpartum IUD expands access to effective and long-lasting contraceptive methods, combining provision during childbirth with prenatal information and ensuring women's right to information and free choice. The increase in this indicator across all regions is also related to the escalated information campaigns aimed at the population<sup>15</sup> and the initiatives promoted by the project itself, such as regional seminars, specific training, and refresher courses, which qualified teams and strengthened the provision of contraceptive methods, especially the postpartum IUD, as part of the guarantee of women's reproductive rights.

During the period analyzed, the items on humanized care in cases of legal abortion and sexual violence fluctuated across all regions. In contrast, the immediate insertion of IUDs after abortion increased from 32.3% to 60.4% between the beginning and the end of the period. The trend toward a reduction in legal abortion and sexual violence care services at the end of the intervention may reflect not only the project's limitations but also the return of pre-existing concepts and positions within the services, which tend to reappear in the lack of continued support, revealing challenges to the sustainability of progress.

In June 2020, the revocation of Technical Note N° 016/2020<sup>29</sup> compromised the recognition of sexual and reproductive health services as essential within the SUS (Unified Health System), exacerbating setbacks in reproductive rights. This decision was part of an institutional necropolitics that contributed to an increase in preventable deaths, exposed gender inequalities, and reduced access to obstetric care. These factors preceded the restrictions imposed on maternal and child health services, showing that the political and health context compounded organizational challenges in women's care<sup>30</sup>.

During the COVID-19 pandemic, hospitals faced restrictions that affected women's care, with the suspension of services such as legal termination of pregnancy, shortages of supplies, and the redirection of professionals, prioritizing care safety<sup>31</sup>. These measures highlighted the challenges imposed by the health crisis on the organization and continuity of hospital operations<sup>31</sup>.

The downward trend of assessment items related to legal abortion care and sexual violence reflected a political and institutional context that weakened reproductive rights during the COVID-19 pandemic. As analyzed by Gonzaga, Amorim, and Calil<sup>32</sup>, the provision of these services was disrupted, driven by the financial dismantling of the Unified Health System (SUS) and cultural and religious barriers, among many others<sup>33</sup>.

This situation was exacerbated by a conservative agenda that, during the pandemic, further exposed the historically restricted sexual and reproductive rights of women in the country. Notably, the implementation of ApiceON began in an unstable political climate. Since the Dilma Rousseff administration's suspension, there has been a progressive weakening of policies aimed at gender equity and sexual and reproductive health<sup>34,35</sup>. This was compounded by the pandemic and led to ApiceON's premature closure.

In this challenging context, marked by varying external pressures and internal

inequalities, the effects of ApiceON varied depending on each service's ability to develop responses aligned with their specific circumstances. The project's impacts were aligned with the unique characteristics of each hospital and region, paving the way for strategies that, even amid constraints, attempted to achieve possible progress, shaped by their structures, resources, and local contexts. This dynamic resulted in distinct movements of innovation and improved practices, reaffirming the project's potential as a driver of institutional change<sup>22,23,36</sup>. Further research will be needed to understand these processes and the tensions between internal and external forces that influenced their implementation in greater depth.

The regional disparities highlighted in the results reflect historical inequalities in the organization of local health systems. While regions like the Northeast and Midwest have advanced in some areas, such as the inclusion of obstetric nurses and the use of postpartum IUDs, others, like the Southeast and North, have faced persistent obstacles in critical areas of care. These variations reflect not only structural differences but also weaknesses in network coordination, political and institutional challenges, and limits on the installed capacity of these services.

In this movement towards care continuity and improvement, we underscore the recent implementation of the Project to Strengthen Obstetric and Neonatal Care by the Brazilian Hospital Services Company (EBSERH), in partnership with the Fernandes Figueira National Institute of Women, Children, and Adolescent Health of the Oswaldo Cruz Foundation (IFF/FIOCRUZ)<sup>37</sup>. The initiative aims to improve the care provided in university hospitals through the production of evidence, development of protocols, training, and monitoring of evaluation items, with a focus on reducing maternal and neonatal mortality and the inclusion of vulnerable populations. The convergence of this proposal with the principles and strategies promoted

by ApiceON strengthens the field of analysis and intervention, signaling the importance of monitoring its effects in different regional and institutional contexts, in conjunction with care networks and the SUS commitments to women's rights<sup>38</sup>.

This study had some limitations related to the use of secondary data and the internal evaluation of professionals. However, the collective nature of the analysis increases its validity and allows for more contextualized interpretations of the advances and challenges faced. Furthermore, the results reflect exclusively the project's intervention period and do not encompass changes that occurred later. Also, the decision to group the data by region may restrict the analysis of the specific contexts of each hospital. This decision, however, was necessary to preserve the confidentiality of the participating hospitals.

## Final considerations

Analysis of the results of ApiceON's care component reveals significant progress in incorporating practices aligned with SUS principles and evidence-based obstetric care, especially in aspects related to reception, best practices, and the ambiance. Engaged institutional groups and the adoption of evaluation tools favored shifts in practices, challenging established logics and enabling greater autonomy for women and teams.

Although uneven, the path of change evidenced by the evaluation items indicates the power of interventions based on the analysis of contexts, the strengthening of groups, and the valorization of care production forms. The observed repercussions reflect accumulations that exceed meeting targets, but also express transformations in the daily routine of services, materialized in the expansion of good care practices, the inclusion of obstetric nursing, the appreciation of listening to women, the use of collective analysis and planning tools, and the strengthening of critical reflection

processes among and within teams. These findings reinforce the importance of public policies that recognize services as living territories, intertwined with disputes, potentialities, and possibilities for (re)invention and (co)creation.

The main impact was the movements the services were able to develop with the project, triggering processes that can expand the potential and sustainability of local actions, in dialogue with the uniqueness of each context. Although there are still challenges to be overcome, the results reveal that investing in initiatives to support and strengthen groups is crucial to the sustainable and urgent

transformation of the care model, guided by the principles of comprehensiveness, equity, humanization, and the guarantee of rights.

## Collaborators

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