REVISTA ONLINE DE PESQUISA

CUIDADO É FUNDAMENTAL

UNIVERSIDADE FEDERAL DO ESTADO DO RIO DE JANEIRO • ESCOLA DE ENFERMAGEM ALFREDO PINTO

RESEARCH

DOI: 10.9789/2175-5361.rpcfo.v12.7092

CHILDBIRTH CARE IN A *RIO DE JANEIRO* COASTAL LOWLANDS HOSPITAL: CHALLENGES FOR RESPECTFUL BIRTH

Assistência ao parto em um hospital da baixada litorânea do Rio de Janeiro: desafios para um parto respeitoso

Asistencia al parto en un hospital de una región específica del Rio de Janeiro: desafíos para un parto respetuoso

Julianne de Lima Sales[1], *Jane Baptista Quitete*[2], *Virginia Maria de Azevedo Oliveira Knupp*[3], *Marcilene Andrade Ribeiro Martins*[4]

How to cite this article:
Sales JL, Quitete JB, Knupp VMAO, Martins MAR. Childbirth care in a Rio de Janeiro coastal lowlands hospital: challenges for respectful birth. Rev Fun Care Online. 2020 jan/dez; 12:108-114. DOI: http://dx.doi.org/10.9789/2175-5361.rpcfo.v12.7092.

ABSTRACT

Objective: the study's purpose has been to analyze the childbirth care of women assisted at a public hospital in the coastal lowland of *Rio de Janeiro* State. **Method:** this is a descriptive and cross-sectional study with a quantitative approach that applied the retrospective documentary technique. The research data are related to the births that occured in the institution during the period from January to June 2015. **Results:** a total of 796 births were recorded, 352 (44.22%) occurred by the vaginal route and 444 (55.77%) via abdominal. It was found that primiparous and women over 35 years old were more frequently submitted to cesarean section. Among 352 parturients who had a vaginal delivery, 164 (46.59%) had the episiotomy performed. **Conclusion:** the institution has a high rate of surgical deliveries and obstetric interventions, such as episiotomy, performed routinely and without adequate indication. The assistance is dehumanized and in disagreement with current recommendations and scientific evidence.
Descriptors: Childbirth; Episiotomy; Women's health.

1 Nursing Graduate by the *UFF/UFF/Rio das Ostras* Campus, Resident of Obstetric Nursing at the *UFF*, Researcher of the Research *Group Laboratório de Estudos sobre Mulheres e Enfermagem (LEME)* [Laboratory of Studies on Women and Nursing]/*UFF/Rio das Ostras Campus.*

2 Obstetric Nurse Graduate by the *Universidade Estadual do Rio de Janeiro (UERJ)*, Nursing PhD by the UERJ, Adjunct Professor of the Nursing Department at *UFF*, Coordinator of the Nursing Office of *UFF*, Leader of the *LEME* Research Group/*UFF/Rio das Ostras Campus.*

3 Nurse Graduate by Nurse Specialist in Health Evaluation by the National School of Public Health Sérgio Arouca – Fiocruz, MSc in Nursing and PhD in Health Sciences by the *Universidade Federal do Estado do Rio de Janeiro (UNIRIO)*, Adjunct professor at *UFF/ Rio das Ostras Campus*. Researcher of the Groups *Laboratório sobre Enfermagem, Cuidado, Inovação e Organização da Assistência ao Adulto ou ao Idoso* (*LECIONAI*) [Laboratory on Nursing, Care, Innovation and Organization of Assistance to the Adult or the Elderly], *Estudos sobre Vivências e Integralidade dedicadas à Enfermagem, Criança, Infância, Adolescentes e Recém-nascidos (EVIDENCIAR)* [Studies on Experiences and Integrality dedicated to Nursing, Child, Childhood, Adolescents and Newborns], and *Laboratório de Estudos sobre Mulheres e Enfermagem* (*LEME*) [Laboratory of Studies on Women and Nursing].

4 Obstetric Nurse by the *UERJ*, Nurse at the *Núcleo de Atenção à Saúde da Mulher e da Criança da Secretária Municipal de Macaé/RJ,* Nurse of the Madria home delivery team/*RJ*, Researcher of the *LEME* Research Group/*UFF/Rio das Ostras Campus.*

RESUMO

Objetivo: analisar a assistência ao parto das mulheres assistidas em um hospital público da baixada litorânea do Rio de Janeiro. **Método:** trata-se de um estudo descritivo, de natureza quantitativa, de delineamento transversal, que utilizou a técnica documental retrospectiva. Os dados da pesquisa são relativos aos partos que ocorrem na instituição durante o período de janeiro a junho de 2015. **Resultados:** dos 796 partos, 352 (44,22%) ocorreram por via vaginal e 444 (55,77%) por via abdominal. Constatou-se que as primíparas e as mulheres com mais de 35 anos foram submetidas com maior frequência a cesárea. Das 352 parturientes que tiveram parto vaginal, 164 (46,59%) tiveram a episiotomia realizada. **Conclusão:** a instituição apresenta alto índice de partos cirúrgicos e realização de intervenções obstétricas, tais como a episiotomia, sendo realizada de forma rotineira e sem indicação adequada. A assistência encontra-se desumanizada e em desacordo com as atuais recomendações e evidências cientificas.

Descritores: Parto; Episiotomia; Saúde da mulher.

RESUMEN

Objetivo: analizar la asistencia de parto de las mujeres assistidas en un hospital público de la baixada litorânea del Rio de Janeiro. **Método:** trata de um estúdio descriptivo, de naturaleza cuantitativa, de delineamento transversal, que utiliza la técnica documental retrospectiva. Dado los resultados de la investigación los partos ocurren en instituciones en Enero a Junio de 2015. **Resultados:** de los 796 partos, 352 (44,22%) ocurren por via vaginal, el 444 (55,77%) por via abdominal. Constantemente las mujeres primerisas con más de 35 anos son sometidas con mayor frecuencia a cesárea. Dadas las 352 pacientes que tuvierón parto vaginal, 164 (46,59%) tuvieron una epiosotomía. **Conclusión:** la institución representa un alto índice de partos cirúrgicos y realización de intervenciones obstétricas, tales como una episiotomia, siendo realizada de forma rutinaria y sin indicación adecuada. La asistencia se encuentra desumanizada en desacuerdo con las actuales recomendaciones y evidencias científicas.

Descriptores: Parto; Episiotomia; Salud de la mujer.

INTRODUCTION

Childbirth and birth care have undergone profound transformations in the last decades, moving from the home environment to an institutionalized delivery. A technocratic model was then designed, centered on a perspective that childbirth is a pathological event. Nonetheless, the midwifery art should consider women as protagonists, which must occur as naturally as possible, avoiding the use of unnecessary technologies.[1]

In this sense, Brazil's public policies in the area of women's health have been changed during the last two decades, driven by historical, political, social and economic transformations. Until the last century, the parturient was separated from her family members in the process of parturition, withdrawing her dominion during this process, in which delivery becomes a surgical procedure to be performed in a hospital environment, aseptic and full of interventions.[2,3]

From the 1980s onwards, the movement of humanization of childbirth begins to gain strength and visibility. In 2000, the *Programa de Humanização do Pré-natal e Nascimento (PHPN)* [Prenatal and Birth Humanization Program] was launched, which seeks to restore women's protagonism, the integral vision of childbirth, considering the physiological, emotional, social, cultural aspects and a welcoming, respectful, and scientific evidence-based care.[3,4]

In Brazil, during the years 2010-2015, there were approximately 17 million births, of which 55.23% were by cesarean section.[5] Although there has been an increase in antenatal care coverage, maternal mortality and perinatal mortality, besides the excessive use of interventions during childbirth, such as episiotomy, Kristeller maneuver, and administration of intravenous oxytocin.[6,7]

The World Health Organization (WHO) recommends that cesarean section rates should not exceed 15% of total deliveries. In addition, high rates of surgical delivery are related to undesirable events, such as the birth of preterm infants, low birth weight, respiratory and neurological disorders, as well as puerperal infections.[8]

The advancement of modern obstetrics contributes significantly to the reduction of maternal and perinatal morbidity and mortality, although, the excessive adoption of technologies and procedures, together with the pathological perspective of the puerperal pregnancy period, expose the woman and the newborn child, to unnecessary interventions, devaluing the uniqueness of the mother-baby binomial.[9]

The technological model of Brazilian obstetric assistance reflects in women's care, using interventionist technologies during labor and delivery. The use of these technologies when used unnecessarily can be considered obstetric violence, as they violate the integrity and autonomy of women, for example, we can mention episiotomy.

Besides the fact that the woman is subject to the physical and hormonal alterations of the pregnancy-puerperal process, the practice of episiotomy routinely impacts and causes repercussions in the woman's life, being subjected to the implications of self-esteem, sexuality and increased risk of infection, urinary incontinence and limitations in the puerperium.[10]

The WHO reports that humanizing childbirth is to adopt a set of behaviors and procedures that promote healthy childbirth and birth, respecting the natural process and avoiding unnecessary or risky behaviors for the mother and fetus.[11] Because of this, it is of paramount importance, women's empowerment through access to information, and also qualify the health team to provide evidence-based care.[7]

For the implementation of humanized care, the health team is of great importance, providing a welcoming, respectful and evidence-based care. Health professionals should encourage the parturient to practices that benefit in labor and delivery, and discourage procedures that cause harm to the physiological process of parturition.[12]

Proper delivery is one that ensures the well-being of the mother and the newborn child, whether vaginal or cesarean route. Moreover, the choice of the delivery way should be made according to women's preferences, whenever possible and that the woman may be able to define in an exempt, free and informed manner.[13]

When conducting an empirical analysis of parturient care within the institution under study, it is questioned whether

parturients are being adequately assisted and in accordance with current national and international recommendations and in the light of scientific evidence.

Therefore, the study is justified as a contribution to the improvement of obstetric care in the institution, to promote the importance of humanized, welcoming and respectful assistance, with a focus on women's empowerment about autonomy and the right to choose, material that may be useful for new studies in the area since it is necessary to investigate and stimulate attitudes changes in the reality of Brazilian obstetric care.

Objective

This research aims to analyze the childbirth assistance of women assisted in a public hospital in the coastal lowland of *Rio de Janeiro* State.

METHODS

This is a descriptive and cross-sectional study with a quantitative approach that applied the retrospective documentary technique. The research was conducted in a public hospital in the coastal lowland of *Rio de Janeiro* State.

Research data are related to the 796 deliveries that took place in the institution from January to June 2015. Study's primary data source was the book of records of hospital deliveries, and subsequently, the medical records of vaginal deliveries since some variables of interest were not included in the book. Parturients of twins and stillbirths were adopted as exclusion criteria.

The method used was field research, using a data collection instrument, a checklist type filled out by the researchers themselves. Data collection took place from January to June 2017.

The analyzed variables were: maternal age, gestational age, number of gestations, birth route, APGAR score during the first and fifth minutes, episiotomy and locoregional anesthesia of the pudendal nerve.

APGAR was categorized as 0 to 3, from 4 to 6 and from 7 to 10, which represent the different clinical conditions observed at birth. The total scores from 0 to 3 represent severe suffering, scores from 4 to 6 mean moderate difficulty, and scores from 7 to 10 indicate the absence of adjustment difficulties.[14]

Data processing was performed using the public domain program R (*R Foundation for Statistical Computing*) with relative frequency calculation and central trend measures. Quantitative results were compared to those produced by other Brazilian and international health institutions and analyzed according to the guidelines of the World Health Organization.

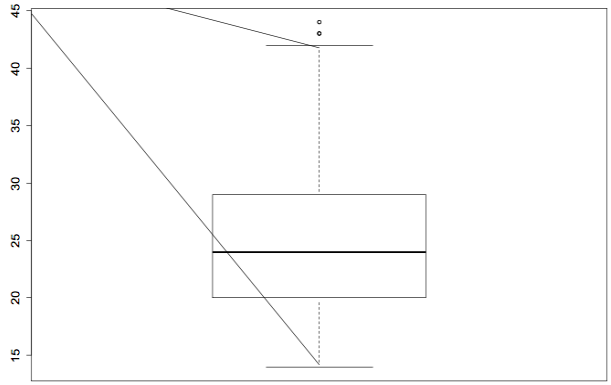
The study was approved by the Ethics Committee of *Hospital Universitário Antônio Pedro (HUAP)*, under the *Certificado de Apresentação para Apreciação* Ética *(CAAE)* [Certificate of Presentation for Ethical Appreciation] No. 52649615.2.0000.5243, respecting the ethical and legal principles that involve the research conducted with human beings, according to resolution No. 466/2012.[15] Nevertheless, because it was a retrospective study with analysis of medical records, in which there was no approach of the users of the health service, research participants, the Free and Informed Consent Term was dispensed.

This academic production is inserted in the line of research entitled: "Sexual and reproductive rights in the attention to childbirth and birth", from the Research Group called *Laboratório de Estudos sobre Mulheres e Enfermagem (LEME)* [Laboratory of Studies on Women and Nursing/ *Rio das Ostras Campus*.

RESULTS AND DISCUSSION

The study analyzed a total of 796 records of births occurring in the institution during the period from January to June 2015. Regarding the profile of parturients attended at the hospital, it was observed that the age group during the study period was from 14 to 44 years old, of these 180 (22.59%) within the age group from 14 to 19 years old, 547 (68.66%) were between 20 and 34 years old and 69 (8.63%) were between 35 and 44 years old. The mean age was 24.8 years old and the median age was 24 years old (**Figure 1**).

Figure 1 - Boxplot of the parturients

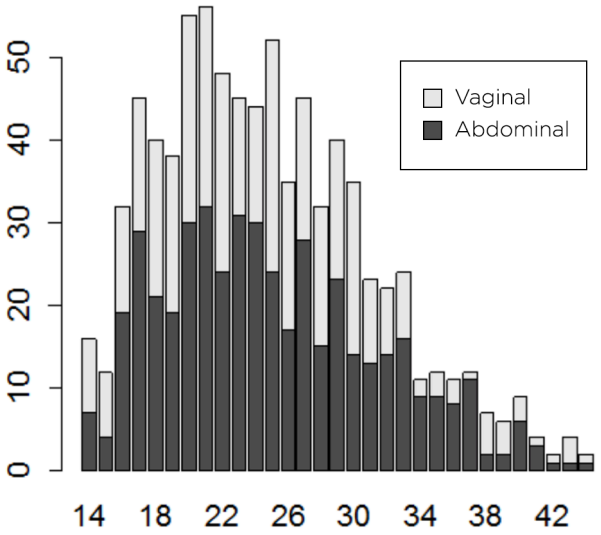


Maternal Age

With regards to the number of pregnancies, 295 (37%) were primigravidae, 238 (29.8%) were at the second pregnancy and 232 (29.1%) were between the third and fifth gestation, and 24 (3.01%) were already in the sixth gestation or more. Among the total number of records analyzed, 14 (1.75%) had no records of obstetric history.

Regarding the delivery route, from the total number 796 childbirths, 352 (44.22%) occurred via vaginal delivery and 444 (55.77%) occurred through the abdominal route. Among the assisted births, primiparous women presented a higher frequency of surgical delivery, that is, of the 295 primiparous women, 168 (56.94%) had delivery via abdominal and 127 (43.05%) via vaginal route. Women over 35 years old are also more likely to undergo a cesarean section, since 69 parturients above 35 years old, 44 (63.76%) had the cesarean section as the chosen delivery method (**Figure 2**).

Figure 2 - Distribution of the birth route according to maternal age (2015).



Concerning the gestational age of parturients, the mean age found was 38.67 years old, according to the amenorrhea time. There were 76 (9.54%) preterm births (less than 37 completed weeks), 699 (87.8%) on term births (37 weeks up to 41 weeks and 6 days) and only 1 (0.12%) postterm birth (42 completed weeks or more). It is worth mentioning that in 20 (2.51%) medical records there were no gestational age records.

In the analysis of birth route related to the gestational age of parturients, 151 (34%) of the 444 abdominal deliveries occurred before the 39th week of gestation, and 34 (7.65%) of them were preterm births.

Considering the APGAR score in the first minute, abdominal newborns (7.65%) presented a score between 4 and 6 in a higher proportion than those born through vaginal route (5.68%). Regarding the APGAR score in the 5th minute, it was also found that while in vaginal delivery the percentage of APGAR of 4 to 6 is 0.56%, in abdominal delivery it is 1.56%. In 12 (1.50%) medical records were not found reports of the APGAR score.

Table 1 - The APGAR score related to the birth delivery route at the 1st minute (2015).

Route of birth deliver	APGAR score					
	0-3		4-6		7-10	
	n	%	N	%	n	%
Vaginal	4	1.13	20	5.58	320	90.90
Abdominal	7	1.57	34	7.65	399	89.86

Table 2 - The APGAR score related to the birth delivery route at the 5th minute (2015).

Route of birth delivery	APGAR score					
	0-3		4-6		7-10	
	n	%	N	%	n	%
Vaginal	0	0	2	0.56	342	97.1
Abdominal	1	0,22	7	1.57	432	97.29

Among 352 parturients who had a vaginal delivery, 164 (46.59%) were submitted to the episiotomy procedure. It is noteworthy that 33 (9.37%) medical records had no record of performing this procedure, and 26 (7.38%) medical records were not found in the institution's archive sector.

Furthermore, when analyzing the episiotomy proportion according to parity, it was observed that of the 127 primiparous women who had a vaginal delivery, 84 (66.14%) underwent episiotomy, considering that 12 (9.44% medical records were not found or had no information about the procedure. Whereas, 225 multiparous women who had a vaginal delivery, only 80 (35.55%) were submitted to an episiotomy. In 47 (20.88%) medical records were not found on this procedure.

Table 3 - Numerical and proportional distribution of episiotomy according to parity, 2015.

	Primiparous (n=127)				Multiparous (n=225)			
Episiotomy (n=164)	Yes		No		Yes		No	
	n	%	n	%	n	%	n	%
	84	66,14	31	24.40	80	35.55	98	43.55

When investigating the episiotomy procedure performed with the pudendal nerve anesthetic block, it was found a failure in the medical records of the files in this type of record, since the information about the anesthetic procedure was non-existent in most of the analyzed medical records. Thus, it became impracticable to analyze this variable.

The parturients age group of the study is in line with the Brazilian scenario since a considerable number of women under 20 years old were observed. According to the Ministry of Health, the proportion of live births by maternal age in Brazil between 10 and 19 years old is declining, in 1996 it was 22.9%, and in 2007 there was a drop to 21.1%. In 2015, *Rio de Janeiro* State, the maternal age found was about 17%, a little lower than the reality in the institution studied.[16]

We emphasize that sexual activity when initiated early can lead to unwanted pregnancies, increased frequency of sexually transmitted infections, and pregnancy in adolescence can lead to maternal and fetal complications. As a result,

the role of primary care should be highlighted in the face of this challenge, aiming to promote sexual and reproductive education, to establish adolescents' ties and trust relationships, as well as to encourage safer sex, by taking into consideration the socio-cultural and economic aspects.[17]

The high number of surgical deliveries reflects the current scenario of Brazilian obstetric care. In Brazil, the rate of cesarean delivery in the public network is approximately 52% of births. Nonetheless, the World Health Organization recommends that the ideal rate for cesarean section is between 10% and 15% of total deliveries, rates greater than 10% are not associated with a reduction of maternal and neonatal morbidity and mortality.[18,19]

A cesarean section is critical to saving lives, as long as it is really needed and has an indication based on scientific evidence. Although, the high number of abdominal deliveries evidences the absence of protocols and monitoring of cesarean section indications in the institution.[9] The Ministry of Health recommends that: in preterm births and small fetuses for gestational age, the routine cesarean section should not be performed. Moreover, the scheduled surgical delivery should not be performed before 39 weeks of gestation.

Maternal morbimortality is increased in women submitted to cesarean section, and when performed early, raises the risks of hospitalization in neonatal intensive care/specialized neonatal care and morbidity. The most common complications of cesarean section are postpartum haemorrhage, venous thromboembolism, and puerperal infection. When there is no maternal or fetal indication, vaginal delivery is recommended because it is more appropriate and safer for the woman.[9,20]

In this study, it was also found that maternal age (above 35 years old) and primiparity are directly related to the highest cesarean rate. These data are similar to other studies and justified by the fact that women with advanced maternal age are more susceptible to a higher incidence of clinical and obstetric complications, unfavorable fetal impairment and anxiety of the medical team, thus increasing the number of surgical deliveries without an adequate indication.[21,22]

Cesarean section in primiparous women may cause injury since the high incidence of indication for surgical delivery due to previous cesarean section. Several studies have indicated a higher risk of morbidity in cesarean than in vaginal delivery, as well as a higher frequency of complications in subsequent cesarean sections. These risks should be considered by the health team and informed to the woman.[23,24]

The choice of the delivery route should be made by the pregnant woman, based on the risks, benefits, possible future complications and maternal and neonatal outcomes, however, there is still a deficiency in the dialogue and the transmission of information between the health professional and the woman. Also, according to Feitosa (2017), women's discourses are collectively transmitted through the choice of delivery, in which normal delivery is synonymous of pain.[25]

In contrast to this reality, studies demonstrate that women prefer the vaginal delivery route, nevertheless, the perpetuation of cultural patterns for choosing the delivery route allied with lack of knowledge, power of intervention of health professionals, mercantilization of childbirth and the lack of interest of physicians by normal childbirth are factors that influence the choice by cesarean section and collaborate with the high indices of surgical deliveries in the scenario of public and private healthcare network in Brazil.[26]

This intervention power of the health professionals and medicalization of the female body, brought some interventional procedures for the woman at the time of delivery and one of them is episiotomy, which should be indicated to reduce or prevent the trauma on birth pathway tissues, prolapses and to avoid lesions of the fetal cephalic pole submitted to the pressure suffered against the perineum. Notwithstanding, its practice has become routine within hospital institutions, without scientific evidence.[27,28]

The data analyzed in this study related to the variable reveal that the episiotomy occurs routinely and without real indications for its accomplishment. Since 1996, episiotomy has been routinely considered by the World Health Organization as a practice often used inappropriately. The *Nascer no Brasil* (2014) research, which interviewed 23,894 women, found that in 56% of the deliveries was performed episiotomy and, almost 75% of the primiparous women were submitted to this procedure.[7]

It is worth mentioning the repercussions caused by episiotomy, since perineal pain is a common cause of puerperal morbidity, making it difficult to self-care and also to care for the newborn.[29] The practice of episiotomy routinely impacts and causes repercussions on women's lives, with implications for self-esteem and sexuality, increasing the risk of infection and fecal urinary incontinence, among other limitations in the puerperium.[10]

According to Francisco (2014), primiparous women are more prone to perineal trauma, especially episiotomy.[30] In addition, multiparous women are three times more likely to remain without perineal traumas than primiparous women.[31] And even when care is provided by obstetrical nurses there is also a predominance of episiotomy in primiparous women.[32] These results coincide with the results found in the study and encourage reflection to change the current Brazilian obstetric care.

Transforming the model of the current Brazilian obstetric care still persists as a challenge for managers and health professionals. It is imperative to promote and rescue the empowerment and physiology of women, to reduce unnecessary interventions, and to use assistive practices based on scientific evidence.[93]

With regards to the analgesia used for pain relief during the episiotomy, there are few studies on the degree of pain during the surgical incision and perineal suture. Nevertheless, because it is a surgical act, it is necessary for the woman to be informed about the benefits and harms of the procedure and authorize it, however, the supremacy of the team prevails, and most women are not aware of such practice. The execution of such procedures without authorization hurts the human rights and autonomy of women and constitutes obstetric violence.[34]

During the study, there were records failures in the parturients' records, data on locoregional anesthesia during childbirth in most of the medical records were not

fulfilled, making it difficult to analyze this procedure within the institution. The medical record registering procedure portrays the type of care provided by the professionals, besides being a legal document, when it is flawed and incomplete, it makes it impossible to determine the care process provided by the health team.[35]

The APGAR score is a method to assess the vitality of the newborn in the first and fifth minutes, through five variables: heart rate, respiratory effort, muscle tone, reflex irritability, and color. The longitudinal measurement of the APGAR report allows evaluating the response of the newborn to the procedures performed, noting that it should not be used as a criterion for initiating neonatal resuscitation. In view of the result of the total scores, it is possible to analyze the adaptation of the newborn to extrauterine life.[14,20,36]

When the influence of the birth route on the APGAR report was analyzed, some studies show that there is a significant difference between vaginal and surgical delivery. Our findings confirm this difference in the APGAR score related to the birth route (in the first and in the fifth minute). [37,38]

Furthermore, transforming the care process during labor, childbirth and the reception of this new being to the world, present maternal and neonatal benefits. And they should be encouraged by the health professional team, reducing invasive technologies and elective cesarean sections, since these procedures increase the risk of neonatal morbidity and mortality.[14,20]

CONCLUSIONS

The study reveals that the institution has a high rate of surgical deliveries to the detriment of vaginal deliveries. It was also noted the performance of obstetric interventions, such as episiotomy, being performed routinely and without adequate indication. Based on these results, and in response to the objective of this manuscript, we consider that delivery care of the women assisted at the institution investigated does not comply with the guidelines of the Humanization Policy of Labor and Delivery and is not in accordance with the international recommendations on attention to childbirth and birth.

Hence, results reiterate the importance of transforming the current model of Brazilian obstetric care, with a view to overcoming existing challenges within the hegemonic biomedical model and to assist in proposing interventions that may qualify attention to childbirth and birth care based on the premise that giving birth and being born are both physiological and family events.

It is hoped that the results of this study may contribute to new research within the thematic and that it helps in the propositions of strategies, and stimulates changes of attitudes in the professionals that attend the deliveries.

The limitations of this study are related to the difficulty of access to medical records due to the shortage of employees in the archive sector, and the poor quality of medical records.

REFERENCES

1. Wolff LR, Moura MAV. A institucionalização do parto e a humanização da assistência: revisão de literatura. Esc Anna Nery Rev Enferm [Internet]. 2004 ago [citado em 2017 nov 21];8(2):279-85. Available at: http://www.redalyc.org/articulo.oa?id=127717713016
2. Reis CSC, Souza DOM, Progianti JM, Vargens OMC. As práticas utilizadas nos partos hospitalares assistidos por enfermeiras obstétricas. Enfermagem Obstétrica [Internet]. 2014 jan-abr [citado em 2017 out 20];1(1):7-11. Available at: http://www.enfo.com.br/ojs/index.php/EnfObst/article/view/3/1
3. Matos GC, Escobal AP, Soares MC, Härter J, Gonzales RIC. A trajetória histórica das políticas de atenção ao parto no Brasil: uma revisão integrativa. Rev enferm UFPE online [Internet]. 2013 mar [citado em 2017 nov 19];7(esp):870-8. Available at: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/download/3347/5741
4. Ministério da Saúde (BR). Programa de Humanização do Pré Natal e Nascimento. Brasília: Ministério da Saúde, 2000.
5. Ministério da Saúde (BR). Sistema de Informações sobre Nascidos Vivos (SINASC). Brasília: Ministério da Saúde, 2015
6. Silva FMB, Paixão TCR, Oliveira SMJV, Leite JS, Riesco MLG, Osava RH. Assistência em um centro de parto segundo as recomendações da Organização Mundial da Saúde. Rev Esc Enferm USP [Internet]. 2013 out [citado em 2017 nov 21];47(5):1031-38. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-62342013000501031&lng=en.
7. Leal MC, Pereira APE, Domingues RMSM, Filha MMT, Dias MAB, Nakamura PM et al. Intervenções obstétricas durante o trabalho de parto e parto em mulheres brasileiras de risco habitual. Cad Saúde Pública [Internet]. 2014 [acesso em 2017 nov 21];30(Suppl1): 17-32. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102311X2014001300005&lng=en.
8. Oliveira RR, Melo EC, Novaes ES, Ferracioli PLRV, Mathias TAF. Fatores associados ao parto cesáreo nos sistemas público e privado de atenção à saúde. Rev Esc Enferm USP [Internet]. 2016 [citado em 2017 out 10];50(5):734-41. Available at: http://www.scielo.br/pdf/reeusp/v50n5/pt_0080-6234-reeusp-50-05-0734.pdf
9. Ministério da Saúde (BR). Secretaria de Ciência, Tecnologia e Insumos Estratégicos. Diretriz Nacional de Assistência ao Parto Normal. Brasília: Ministério da Saúde, 2016.
10. Lopes DM, Bonfim AS, Sousa A, Reis L, Santos L. Episiotomy: feelings and consequences experienced by mothers. Rev pesqui cuid fundam Online [Internet]. 2012 jan 3; [citado em 2017 nov 21];4(1):2623-35. Available at: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/1532
11. Santos IS, Okazaki ELFJ. Assistência de enfermagem ao parto humanizado. Rev Enferm UNISA [periódico na Internet]. 2012 [citado em 2017 out 5];13(1): 64-8. Available at: http://www.academia.edu/23294814/Assist%C3%AAncia_de_enfermagem_ao_parto_humanizado
12. Sousa AMM, Souza KV, Rezende EM, Martins EF, Campos D, Lansky S. Practices in childbirth care in maternity with inclusion of obstetric nurses in Belo Horizonte, Minas Gerais. Esc Anna Nery [Internet]. 2016 Jun [citado em 2017 nov 21];20(2): 324-31. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414814520160002003 24&lng=en.
13. Patah LEM, Malik AM. Modelos de assistência ao parto e taxa de cesárea em diferentes países. Rev Saúde Pública [Internet]. 2011 fev [citado em 2017 out 21]; 45(1): 185-94. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102011000100021&lng=en.
14. Honckenberry MJ, Wilson D. Wong Fundamentos de Enfermagem Pediátrica. 9. ed. Rio de Janeiro: Elsevier, 2014.
15. Ministério da Saúde (BR). Resolução n. 466, 12 de dezembro de 2012. Diretrizes e normas reguladoras de pesquisas com seres humanos. Brasília: Conselho Nacional de Saúde, 2012.
16. Ministério da Saúde (BR). Sistema de Informações sobre Nascidos Vivos (SINASC). 2015 [acesso em 2017 nov 21]. Available at: http://datasus.saude.gov.br/
17. Almeida TM, Rocha LS. Gravidez na adolescência: reconhecimento do problema para atuação do enfermeiro na sua prevenção. In: Anais VII Simpósio de Produção Acadêmica; 2015 jan-dez; 7(1). Minas Gerais (MG): Univiçosa; 2015. p 222-27.

18. Leal MC, Silva AAM, Dias MAB, Gama SGN, Rattner D et al. Birth in Brazil: national survey into labour and birth. Reproductive Health [Internet]. 2012 Aug [acesso em 2017 Nov 01]; 9(15). Available at: https://www.ncbi.nlm.nih.gov/pubmed/22913663.

19. World Health Organization (WHO). Appropriate technology for birth. Lancet. 1985; 2(8452):436-7.

20. Montenegro CAB, Rezende Filho JR. Rezende obstetrícia. 13º ed. Rio de Janeiro (RJ): Guanabara Koogan; 2017.

21. Andrade PC, Linhares JJ, Martinelli S, Antonini M, Lippi UG, Baracat FF. Resultados perinatais em grávidas com mais de 35 anos: estudo controlado. Rev Bras Ginecol Obstet. [Internet]. 2004 out [citado em 2017 nov 27]; 26(9): 697-701. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0100-72032004000900004&lng=en.

22. Cabral SALCS, Costa CFF, Cabral Júnior SF. Correlação entre a idade materna, paridade, gemelaridade, síndrome hipertensiva e ruptura prematura de membranas e a indicação de parto cesáreo. Rev Bras Ginecol Obstet. [Internet]. 2003 dez [citado em 2017 Nov 27];25(10):739-44. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0100-72032003001000007&lng=en.

23. Liu S, ListonRM, Joseph KS, Heaman M, Sauve R, Kramer MS et al. Maternal mortalityandseveremorbidityassociatedwithlow-riskplannedcesarean delivery versus planned vaginal delivery at term. CMAJ: Canadian Medical Association Journal [Internet]. 2007 Feb 13 [citado em em 2017 Nov 2017]; 176(4): 455–60. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1800583/

24. Miller ES, Hahn K, Grobman WA. Consequences of Primary Elective Cesarean. Obstetrics & Gynecology [Internet]. 2013 Apr [citado em 2017 Oct 20]; 121(4): 789-97. Available at: http://journals.lww.com/greenjournal/Abstract/2013/04000/Consequences_of_a_Primary_Elective_Cesarean.14.aspx

25. Feitosa RMM, Pereira RD, Souza TJCP, Freitas RJM, Cabral SAR, Souza LFF. Fatores que influenciam a escolha do tipo de parto na percepção das puérperas. Revista de Pesquisa: Cuidado é Fundamental Online [Internet]. 2017 jul 1 [citado em 2017 nov 29]; 9(3):717-26. Available at: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/5502

26. Copelli FHS, Rocha L, Zampieri MFM, Petters VR, Gregório, Custódio ZAO. Fatores determinantes para a preferência da mulher pela cesariana. Texto Contexto Enferm [Internet]. 2015 abr-jun [citado em 2017 out 20]; 24(2): 336-43. Available at: http://www.scielo.br/pdf/tce/v24n2/pt_0104-0707-tce-24-02-00336.pdf

27. Oliveira APG, Machado DS, Silva JM, Chevitarese L. Episiotomia: discussão sobre o trauma psicológico e físico nas puérperas -uma revisão bibliográfica. Revista Rede de Cuidado em Saúde [Internet]. 2016 [citado em 2017 nov 29]; 10(1): 1-13. Available at: http://publicacoes.unigranrio.com.br/index.php/rcs/article/view/3311/1512

28. Bolsoni AC, Coelho JA. Episiotomia no puerpério: percepção das mulheres. Revista De Saúde Pública Do Paraná [Internet]. 2016 dez [citado em 2017 out 10]; 17(2): 199-205. Available at: http://www.uel.br/revistas/uel/index.php/espacoparasaude/article/view/26749/pdf20

29. Beleza ACS, Ferreira CHJ, Sousa L, Nakano AMS. Mensuração e caracterização da dor após episiotomia e sua relação com a limitação de atividades. Rev Bras Enferm [Internet]. 2012 mar-abr [citado em 2017 out 20]; 65(2):264-8. Available at: http://www.scielo.br/pdf/reben/v65n2/v65n2a10.pdf

30. Francisco AM, Kinjo MH, Bosco CS, Silva RL, Mendes EPB, Oliveira SMJV. Associação entre trauma perineal e dor em primíparas. Rev Esc Enferm USP [Internet]. 2014 [citado em 2017 out 12]; 48(Esp):40-5. Available at: http://www.scielo.br/pdf/reeusp/v48nspe/pt_0080-6234-reeusp-48-esp-040.pdf

31. Smith LA, Price N, Simonite V, Burns EE. Incidence of na drisk factors for perineal trauma: a prospective observational study. BMC Pregnancy Childbirth [Internet]. 2013 [citado em 2017 out 12];13(59): 1-9. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3599825/pdf/1471-2393-13-59.pdf

32. Figueiredo GS, Santos TTR, Reis CSC, Mouta RJO, Progianti JM, Vargens OMC. Ocorrência de episiotomia em partos acompanhados por enfermeiros obstetras em ambiente hospitalar. Rev enferm UERJ [Internet] 2011 abr-jun [citado em 2017 out 11]; 19(2):181-5. Available at: http://www.facenf.uerj.br/v19n2/v19n2a02.pdf

33. Sousa AMM, Souza KV, Rezende EM, Martins EF, Campos D, Lansky S. Práticas na assistência ao parto em maternidades com inserção de enfermeiras obstétricas, em Belo Horizonte, Minas Gerais. Esc Anna Nery [Internet]. 2016 [citado em 2017 out 29];20(2):324-331. Available at: http://www.scielo.br/pdf/ean/v20n2/1414-8145-ean-20-02-0324.pdf

34. Costa NM, Oliveira LC, Solano LC, Martins PHMC, Borges IF. Episiotomia nos partos normais: uma revisão de literatura. Facene/Famene [Internet] 2011 [citado em 2017 nov 20]; 9(2): 45-50. Available at: http://www.facene.com.br/wp-content/uploads/2010/11/2011-2-pag-45-50-Episiotomia.pdf

35. Setz VG, D'Innocenzo M. Avaliação da qualidade dos registros de enfermagem no prontuário por meio da auditoria. Acta paul enferm [Internet]. 2009 jun [citado em 2017 nov 29];22(3):313-17. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-21002009000300012&lng=en.

36. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Atenção à saúde do recém-nascido: guia para os profissionais de saúde. 2. ed. atual. Brasília: Ministério da Saúde, 2014.

37. Kilsztajn S, Lopes ES, Carmo MSN, Reyes AMA. Vitalidade do recém-nascido por tipo de parto no Estado de São Paulo, Brasil. Cad Saúde Pública [Internet]. 2007 ago [citado em 2017 nov 28];23(8):1886-92. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2007000800015&lng=en.

38. Franceschini DTB. Comparação da vitalidade entre recém-nascidos de parto normal e de cesárea [monografia] Porto Alegre: Universidade Federal do Rio Grande do Sul, UFRS; 2006.

Received in: 10/12/2017
Required revisions: Did not thave
Approved in: 09/04/2018
Published in: 10/01/2020

Corresponding author:
Julianne de Lima Sales
Address: Rua Dr. Batista, 20, Bairro Fazendinha
Rio de Janeiro, Brazil
Zip code: 28.970-000
E-mail address: j.salees@gmail.com
Telephone numbers: +55 (22) 97401-1591

Disclosure: The authors claim to have no conflict of interest.