Saúde e Pesquisa
DOI: 10.17765/2176-9206.2024v17n1.e12057

Obstetric practices and childbirth care: a mixed method study

Práticas obstétricas e assistência ao parto: estudo de método misto

Maria Aparecida Baggio[1], Ana Paula Contiero[2], Taís Regina Schapko[3]

[1]Departamento de Enfermagem. Programa de Pós-graduação em Saúde Pública em Região de Fronteira, Universidade Estadual do Oeste do Paraná (UNIOESTE). Cascavel (PR), Brasil. [2]Departamento de Enfermagem. Programa de Pós-graduação em Saúde Pública em Região de Fronteira, Universidade Estadual do Oeste do Paraná (UNIOESTE). Foz do Iguaçu (PR), Brasil.

[3]Prefeitura Municipal de São Miguel do Iguaçu (PR), Brasil.

RESUMO

Identificar as práticas obstétricas empregadas na assistência ao parto e à associação entre condições obstétricas e sociodemográficas das mulheres com a via de parto. Estudo de método misto, do tipo concomitante, com 399 puérperas, por meio de entrevistas estruturadas e semiestruturadas, dados de prontuários e caderneta da gestante, entre agosto de 2017 a março de 2018, em uma maternidade pública do Paraná. Utilizou-se análise de conteúdo e teste do qui-quadrado para analisar os dados. Foram identificadas frequentes intervenções obstétricas na assistência ao parto, sendo as principais: uso de ocitocina, amniotomia, exames vaginais repetidos, episiotomia. O parto vaginal esteve associado à idade materna, risco habitual, membranas rotas, dinâmica uterina ausente e dilatação uterina maior que cinco na admissão. Conclui-se que há uso frequente de práticas prejudiciais, ineficazes ou usadas de modo inadequado e incipiente uso de práticas que devem ser estimuladas.

Palavras-chave: Obstetrícia. Parto. Saúde da mulher.

ABSTRACT

To identify the obstetric practices used in childbirth care and the association between obstetric and sociodemographic conditions of women and the route of delivery. This was a concurrent mixed-method study with 399 postpartum women, which used structured and semi-structured interviews, data from medical records, and the pregnant woman's health record between August 2017 and March 2018 in a public maternity hospital in the state of Paraná. Content analysis and a chi-square test were used to analyze the data. Frequent obstetric interventions in childbirth care were identified, mainly the use of oxytocin, amniotomy, repeated vaginal exams, and episiotomy. Vaginal birth was associated with maternal age, usual risk, ruptured membranes, absent uterine dynamics, and uterine dilation greater than five on admission. In conclusion, there is frequent use of harmful, ineffective, or inappropriately used practices and incipient use of practices that should be encouraged.

Keywords: Obstetrics. Parturition. Women's Health.

INTRODUCTION

In Brazil, the main women's health care policies and programs about obstetric care include the Program for Women's Health Care (PAISM), implemented in 1984,[1] the Program for Humanization of Prenatal Care and Childbirth (PHPN), started in 2000, the National Policy for Women's Health (PNAISM), implemented in 2004, and the Cegonha Network, in 2011.[2-5] The state of Paraná has the Paraná Mother's Network Program, implemented in 2012, whose objective is to qualify assistance during prenatal care, childbirth and the postpartum period, aiming to reduce maternal and child morbidity and mortality.[6]

In the global setting, in relation to the quality of childbirth care, in 1996, the World Health Organization (WHO) classified practices related to vaginal birth into four categories: demonstrably useful practices, which should be encouraged; practices that are clearly harmful or ineffective and must be eliminated; practices for which there is insufficient evidence to support a clear recommendation, and therefore should be used with caution; and practices that are frequently used inappropriately. These categories were updated in 2018 and consider the usefulness, effectiveness, and absence of dangerousness of obstetric practices and continue to be recommended, as they are based on diverse scientific evidence.[7]

Likewise, in 2017, in Brazil, the National Guidelines for Assistance to Vaginal Birth were published, which, after systematically synthesizing and evaluating scientific evidence regarding practices in labor and childbirth assistance, subsidizes and guides care for women in labor, intending to promote, protect and encourage vaginal childbirth.[8]

In 2018, the WHO released recommendations for care during childbirth for a positive birth experience. These recommendations focus on care for women and newborns to benefit their health and well-being, in particular women with the possibility of giving birth to a healthy baby in a safe environment from a clinical and psychological point of view, with the support of professionals prepared to birth assistance, friendly and technically competent. These recommendations are based on the premise that women who want physiological labor and childbirth can be included in decision-making, even when these involve medical interventions.[7]

Although there are national and international policies, programs, and strategies for adequate childbirth care, in Brazil, there is still a prevalence of obstetric interventions in birth care in maternity hospitals, such as the use of oxytocin, artificial rupture of membranes, instrumental birth, episiotomy, repetitive vaginal exams, Kristeller maneuver.[9,10] Evidence indicates that episiotomy can increase perineal trauma, pelvic floor dysfunction, and anal sphincter dysfunction, in addition to urinary or fecal incontinence.[11]

In Spain, a multicenter study shows that women who have birth plans (used to express desires and expectations regarding childbirth) are older, more educated, and commonly primiparous and that cesarean sections were less common in women with birth plans. However, the study found no difference between women with and without a birth plan concerning instrumental birth, lacerations, or episiotomy rate.[12]

For better assistance to parturient women, knowledge of the sociodemographic and obstetric profile is necessary, which allows contributing to the actions developed and the way of caring for and assisting this population. The understanding and interpretation of this information and its application in clinical practice can support the planning of childbirth care, the promotion of the health of women of childbearing age, and the prevention of complications inherent to the pregnancy-puerperal cycle.[13]

In this sense, the question is: "What are the obstetric practices used during childbirth

care and associations between obstetric and sociodemographic characteristics of women and the route of delivery?." To clarify this question, this study aimed to identify the obstetric practices used in childbirth care and the association between obstetric and sociodemographic conditions of women and the route of delivery.

METHODOLOGY

This was a concurrent mixed-method study with 399 postpartum women in a public maternity hospital that is a reference for high-risk birth care for the 10th Health Regional Division of the state of Paraná.

Postpartum women with gestational age equal to or greater than 37 weeks, who got prenatal care in the public health system, and who were hospitalized in the rooming-in sector after 24 hours postpartum were included. Postpartum women under 18 years of age and those who gave birth outside the hospital were excluded.

To select the participants, a sample calculation was carried out based on the number of births that occurred in 2016, obtained from the Live Birth Information System (SINASC), considering **N** size (number of elements) of the population; **n** size (number of elements) of the sample; **n^{o}** the first approximation for the sample size; **E0** acceptable margin of error in sampling, resulting in a sample of 399 women for the quantitative part.

For the qualitative part, ten postpartum women were interviewed, considering the study's inclusion criteria. Upon data saturation, which converged on the same themes, the interviews were ended.

Data were collected from August 2017 to March 2018 by undergraduate nursing students and master's students from the Public Health program of a public educational institution who were previously trained. Data were collected from medical records, the pregnant woman's health record, and interviews guided by a structured and semi-structured instrument with postpartum women selected by convenience.

To collect quantitative data, a structured, validated instrument was used, developed by researchers with expertise in maternal and child health. The instrument contained sociodemographic variables: age; race; education; marital status; maternal occupation; family income; receipt of allowance; and variables of obstetric conditions: risk classification; previous pregnancies; uterine dilation and dynamics, status of membranes; the presence of vaginal bleeding upon hospital admission; complications intrapartum; route of delivery; delivery option, and variables about the care provided during childbirth: the presence of a companion, vaginal examination and the professional who made it; use of oxytocin; water and food intake during labor; birth position; guidance on childbirth; use of non-pharmacological methods for pain relief.

Qualitative interviews were guided by a semi-structured instrument, audio-recorded, and began with the question: "Describe the care received during childbirth." Subsequently, other questions were presented to the women to deepen the interviews. To guarantee anonymity, participants were identified with the letter W (woman) and a number corresponding to the interview order, being W1, W2, W3, successively.

Quantitative data were entered in Microsoft Excel® spreadsheets. For the association between different sociodemographic and obstetric variables and delivery routes, the Chi-square test of independence was applied, followed by the post hoc adjusted residuals, which allows the identification of categories with which the variables present a statistical association. For all tests, a significance level of 5% was assumed, and all analyses were carried out using the licensed program XLStat, version 2017.

Qualitative data were transcribed in full and analyzed using the thematic content analysis technique. In the pre-analysis, data were read and organized; when exploring the material, the units of meaning were identified, which gave rise to the category and subcategories; in the treatment of data obtained and interpretation, the content was interpreted considering the proposed objective.[14]

The study is derived from the database of a main, multicenter project, entitled *Paraná Mother's Network in the User's Perspective: the Care of Women During Prenatal Care, Childbirth, the Postpartum Period, and the Child*, approved by the Human Research Ethics Committee of the State University of Londrina, CAAE 67574517.1.1001.5231, opinion 2.053.304. Authorization was obtained from the field of study to use data from medical records, and prior agreement was obtained from the study participants by signing the Informed Consent.

RESULTS

Participants were 399 postpartum women with an average age of 26.76 ± 6.21 years, the majority of whom were white 64.4% (257), with up to eight years of education (214) 53.6%. 92.8% (371) had a partner, who was the main provider for 43.6% (174). Family income was between R$ 2,170.39 ± 1,273.32, and 13.5% (54) depended on some government allowance to support the family.

Vaginal birth was found for 56.1% (224) of participants and cesarean section for 43.8% (175). When analyzing the association between sociodemographic variables and the delivery route, only the variable "maternal age" (^{2}=6.06; p=0.048) showed a statistical association (p<0.05), making it possible to verify that women aged less than or equal to 19 years were those who most frequently underwent vaginal births (Table 1).

Table 1. Sociodemographic variables associated with the route of delivery. 10th Regional Health Division, state of Paraná, Brazil. 2017-2018

Variables	Categories	Vaginal birth		Cesarean birth		
		n	%	n	%	p-value*
Maternal age (n=399)	≤ 19 years	36	16.07	16	9.14	0.048
	20 to 39 years	182	81.25	149	85.15	
	≥ 40 years	6	2.68	10	5.71	
Race (n=387)	White	137	63.43	116	67.84	0.423
	Black	14	6.48	5	2.92	
	Yellow	0	0.00	0	0.00	
	Brown	64	29.63	49	28.65	
	Indigenous	1	0.46	1	0.58	
Maternal Schooling (n=399)	≤ 8 years	75	33.48	58	33.14	0.955
	9 to 11 years	128	57.14	99	56.57	
	≥ 12 years	21	9.38	18	10.29	
Marital status (n=399)	With companion	208	92.86	156	89.15	0.182
	No companion	16	7.14	19	10.85	
Maternal occupation (n=396)	Paid	110	49.55	90	51.72	0.668
	Without remuneration	112	50.45	84	48.29	
Family income (n=345)	≤ 1 minimum wage (WG)	13	6.57	10	6.80	0.497
	From 1 to 2 WG	79	39.90	61	41.50	
	From 2 to 3 WG	68	34.34	45	30.61	
	From 3 to 5 WG	34	17.17	23	15.65	
	Above 5 WG	4	2.02	8	5.44	
Family allowance (n=396)	Yes	23	10.31	19	10.98	0.830
	No	200	89.69	154	89.02	

*p-value of the Chi-square test of independence.

Most pregnant women, 74.5% (297), were classified as having usual risk or intermediate risk, while 25.5% (102) were considered as high risk. Regarding maternal and fetal conditions upon admission, almost all women showed no changes in vital signs, 89.0% (335).

When obstetric variables related to the route of delivery were analyzed, the only variables with no statistical association ($p>0.05$) were vaginal bleeding; intrapartum complications; changes in vital signs; previous pregnancy; companion during labor, with all other variables being associated ($p<0.05$) with the route of delivery.

Vaginal birth was associated with dilation of 8 to 10 cm at the time of admission, ruptured membranes, present uterine dynamics, as well as a history of previous vaginal birth, and the pregnant woman's option for vaginal birth (Table 2).

In turn, cesarean section was associated with high-risk pregnancy, cervical dilation between 0 and 4 cm upon admission, absent uterine dynamics, intact membranes, previous cesarean section, and the pregnant woman's option for having a cesarean section (Table 2).

Table 2. Obstetric variables related to the route of delivery. 10th Regional Health Division, state of Paraná, Brazil. 2017-2018

Variables	Categories	Vaginal birth		Cesarean birth		
		n	%	n	%	p-value*
Risk classification (n=399)	Usual risk	114	50.89	86	49.15	0.010
	Intermediate risk	64	28.57	33	18.85	
	High risk	46	20.54	56	32.00	
Cervical dilation (n=285)	0 to 4 cm	61	31.44	66	72.53	< 0.0001
	5 to 7 cm	53	27.32	7	7.69	
	8 to 10 cm	80	41.24	18	19.78	
Uterine dynamics (n=271)	Present	165	95.38	36	36.73	< 0.0001
	Absent	8	4.62	62	63.27	
State of the membranes (n=301)	Integral	100	55.87	95	77.87	< 0.0001
	Ruptured	79	44.13	27	22.13	
Vaginal bleeding (n=296)	Present	29	16.67	11	9.02	0.058
	Absent	145	83.33	111	90.98	
Intrapartum complications (n=399)	Yes	20	9.30	21	13.04	0.249
	No	195	90.70	140	86.96	
Change in vital signs (n=376)	Yes	23	10.31	19	10.98	0.830
	No	200	89.69	154	89.02	
Previous pregnancy (n=399)	None	90	40.00	61	34.86	0.293
	Multiparous	134	60.00	114	65.14	
Type of previous birth (n=233)	Vaginal Birth	114	87.02	29	28.43	< 0.0001
	Cesarean section	17	12.98	73	71.57	
Delivery option of the pregnant mother (n=389)	Vaginal Birth	195	89.04	89	52.35	< 0.0001
	Cesarean section	24	10.96	81	47.65	

*p-value of the Chi-square test of independence.

The obstetric practices used during labor are listed in Table 3, in which almost half of the women used oxytocin and episiotomy. The birth was mainly accompanied by a physician and just over half of the women had a companion present.

Table 3. Obstetric practices used during labor in the 10th Regional Health Division, state of Paraná, Brazil. 2017-2018

Variable	Description	n	%
Use of oxytocin (n=379)	Yes	180	47.50
	No	199	52.50
Venous access (n=399)	Yes	289	72.43
	No	110	27.57
Vaginal touch (n=388)	Yes	375	96.65
	No	13	3.35
Consent to vaginal examination (n=375)	Yes	358	95.47
	No	17	4.53
Vaginal examination by several people (n=375)	Yes	86	22.93
	No	289	77.07
Rupture of membranes (n=172)	Spontaneous	132	76.75
	Artificial	40	23.24
Liquid intake (n=399)	Yes	120	30.07
	No	279	69.93
Food intake (n=399)	Yes	50	16.72
	No	349	87.47
Episiotomy (n=225)	Yes	98	43.55
	No	127	56.45
Presence of companion (n=399)	Yes	209	52.38
	No	190	47.62
Birth position (n=399)	Lithotomy	215	53.88
	Dorsal non-lithotomy	175	43.85
	Four support	5	1.25
	Squatting	3	0.77
	Vertical	1	0.25
Professional who accompanied (n=393)	Resident doctor	391	99.50
	Nurse/resident	2	0.50

*p-value of the Chi-square test of independence.

The thematic category "Childbirth care" presents two subcategories that give voice to the aforementioned quantitative data regarding obstetric interventions. The subcategory "Harmful, ineffective or inappropriately used practices" highlighted the practices still present in the maternity hospital studied, namely: supine position during labor, repeated or frequent vaginal exams carried out by several people, routine use of oxytocin, amniotomy, pressure on the fundus of the uterus, transfer of the parturient to the delivery room/table, episiotomy, and lithotomy position for delivery, which confirm the quantitative data. In addition to the statements confirming the practices researched in the quantitative phase, intestinal washing and manual exploration of the uterus after childbirth were identified through the statements.

[...] the boy made the examination and then called someone else to make it again [...] they were examining me all the time and with the door half open. Wow, it was horrible! And they didn't tell me anything [...]. I thought it was too much all the time there examining and touching, it hurts a lot [...] I couldn't walk because of the IV that was connected to the wall [...] I had to stay in bed [...]. [...] I had to walk to the delivery room [...] they said that was just the way it was and that I had to walk quickly; otherwise, the baby would be born right there in the bed, and it would tear me up. They had to make the cut to help the baby be born [...]. They didn't say anything; I just felt the pain of cutting; I screamed even more, and the doctor said she had given anesthesia, that I wasn't supposed to scream like that [...] after the placenta came out, she had to do an examination that hurt a lot (M5)

[...] they came to do the vaginal examination [...] they put a pill [...] then went to the IV and then [the contractions] started [...] left [to the delivery room], I got on the stretcher [...] a bad feeling [...] I don't think I needed to go there [delivery room] walking [...] if I pushed out there, he [baby] would fall. Then my water broke [...]. I just held the iron and waited for the contraction and pushed [...]. (M3)

[...] they took me to the delivery room [..] almost when the baby was born, the doctor asked the girl who was there to help by pushing on my belly when I was having a contraction. (M7)

[...] she [the doctor] only said to breathe properly [...] she broke my water. (M1)

[...] they put the pill in the morning and the afternoon, and they put on an IV to relieve pain. And they told us not to push yet [...]. When it was night, I was tired [...] they told me not to eat anything. (M4)

[...] they attended me, said that I was going to be hospitalized, that the baby was going to be born [...] my husband went to the hospital and I stayed there [...]. They did the (intestinal) wash [...] they put me on an IV and then went to the delivery room. [...] They broke [amniotic membranes] there in bed. (M6)

The subcategory "Practices that should be encouraged" identified the contradiction of the recommendations, that is, the presence of a companion was commonly denied, the woman did not have the freedom to choose position during labor or at birth, privacy was compromised, food was not offered or encouraged frequently, empathetic support and monitoring of the woman's physical and emotional well-being by service providers were shown to be compromised, the provision of information and explanations the parturient woman wants, or needs were not considered, in addition to the woman's choices and desires regarding the route of delivery not being considered.

[...] I had to lie down on the stretcher because the IV was in a machine that had to be plugged in and I couldn't walk because of it. They told me to stay quiet [...] that it was like that, and I had to bear it [...] I heard the girl who did my consul-

tation saying: "She wanted a vaginal birth and now that she's in pain, she's there screaming" [...]. The girl who helped me didn't say anything [...] I wanted to know what was happening, but they didn't tell me anything. Then she said to wait as they were seeing what they were going to do, whether they were going to do a cesarean section or not. So, I said that I didn't want to have a cesarean section, that I wanted a vaginal birth. Then the girl giggled and left the room and left me waiting for a while longer [...]. (M7)

[...] no one could stay [...] the nurse said it couldn't, but I knew there was a companion law [...], but they told me there was no space for a companion [...]. My sister was waiting outside [...]. [...] it was already night, I was tired [...], they told me not to eat anything [...]. The baby took a long time to be born; I was pushing, and the contraction came, but it took a long time. And I no longer had the strength (M4)

I really wish my husband had stayed there with me, but they said he couldn't [...]. (M10)

I wanted [the companion's presence]. My husband. It was my first child and my sister, who already has a child, wanted to stay with me, to help me, but the nurse said she couldn't... I knew there was a companion law [...], but they told me there was no space for a companion [...]. I wanted him [husband] to stay there with me, and he also wanted to because he's a big daddy, and he wanted to stay with me. (M3)

[...] They said almost nothing [...] they said to keep walking in the corridor [...]. My husband had to leave and I stayed there walking [...] I told the girl that the pain had gotten worse, but they kept me waiting and didn't say anything [...] at that time we get scared and even alone, it's very difficult at these times [...] I wanted him [husband] to stay there with me. (M5)

DISCUSSION

In this study, most parturient women investigated were young adults, white, with up to eight years of schooling. Similar results were found in a national study that evaluated the Cegonha Network, in public maternity hospitals, revealing that the majority of women in labor were young, aged between 20 and 34, with less than ten years of education, and self-declared black or brown.[9,15]

As for the race of women, this can vary depending on the region of the country. In the north and northeast, most women are brown, while in the south and southeast, white women predominate.[16]

Just over half of the women had a vaginal birth, corroborating a national study that showed that 56.2% of vaginal births were carried out in the public network and more than 80% of cesarean sections in the private network.[9] Such results are still much higher than the WHO recommendation, which recommends cesarean sections at around 15%.[27] Cesarean section rates may refer to the interventionist and medicalization nature of childbirth care, with unnecessary exposure of newborns to risks and complications after birth.[17]

Such findings may indicate the need for changes in culture and educational practices to

reduce unnecessary interventions, especially in the care of pregnant women classified as having habitual risk, as they do not require the interventionist model, but rather monitoring, guidance, care, and support network, which can improve the outcome for the mother and baby.[18]

Vaginal birth was associated with the labor phase, at the time of hospital admission, being more frequent in women who were in labor, in the active phase, although another study points to an increase in vaginal births throughout the years and a greater number of admissions in the latent phase.[19]

Cesarean section, on the other hand, was shown to be related to high-risk pregnancy and absence of labor (cervical dilation between 0 and 4 on admission, absent uterine dynamics, intact membranes), although it is probably related to a previous cesarean section and maternal option for a cesarean section, supported by state law 20,127 of 2020 and which can be carried out after 39 gestational weeks.[20]

Early amniotomy and the use of oxytocin are used in different national and international realities, contrary to WHO recommendations. Likewise, free intake of liquids and food is recommended for women at normal risk during labor. In high-risk patients, research shows that there is not enough evidence to recommend fasting, as Mendelson syndrome - gastric aspiration pneumonitis during anesthesia - was not reported in more than 3,000 women participating in trials included in a systematic review.[7] However, in the present study, the vast majority of women did not receive any liquid or food, disregarding such recommendations.

The most used position during childbirth was the lithotomy position, demonstrating favor to health professionals and not to the woman, as they do not offer the parturient woman other options, confirming the lack of the right to participate in her process of giving birth, denying her freedom of choice.[21]

Among the strategies used to humanize and qualify childbirth care are non-pharmacological methods for pain relief, such as bathing, massages, and using a ball, among others.[2] However, this is not a reality for all women. A study with 10,675 postpartum women, carried out in the five Brazilian macro-regions, showed that half of the women had access to these methods, and in the private network, less than a third of the group used these strategies during labor.[15]

The companion is a fundamental part of the humanization of care, which is why the WHO emphasizes the need for women to be accompanied during the birth process, this being a right provided for by law in Brazil.[22] Nevertheless, in this study, almost half of the women did not have the guaranteed presence of a companion. Another study that analyzed 102 medical records reported that 92.8% of pregnant women had the presence of a companion of their choice during the process of giving birth.[23] The national average was 84.7% presence of companions in 2017.[15]

In this study, almost all births were attended by medical professionals, with little intervention by professional nurses. A study carried out in the Southeast region of Brazil that compared the care provided in public maternity hospitals compared to the care offered in birth centers concluded that birth care provided by obstetric nurses is central to demedicalized care, centered on women's autonomy and rights, offering good practices with the potential to change the obstetric reality in Brazil.[21]

In this sense, nurses, midwives, and nurses graduating from lato sensu graduate programs in the area of obstetrics can contribute to achieving universal coverage of women's health care, from primary to hospital care. The training of these professionals can support necessary changes in childbirth care, such as reducing unnecessary interventions.[24]

Above all, the results indicate the need for health professionals who assist women during prenatal visits to integrate and promote guidance during prenatal consultations to qualify maternal

and child health[25], since the lack of information makes women susceptible to unnecessary interventions due to their lack of knowledge regarding the birth process, leaving them at the mercy of the care model exercised by the team.[26]

Therefore, personal experiences and empirical knowledge should not be recognized as the only references for support and information about labor and birth.[27] Providing precise guidance concerns humanized assistance and is a fundamental attribute of a trained professional.[28]

The study brings contributions and practical implications for health services and professionals working in childbirth care, highlighting the need to reduce unnecessary interventions and encourage the adoption of good obstetric practices in childbirth care. Considering that pregnancy and birth are physiological processes, services and professionals are required to support their practices through care protocols based on scientific evidence, which can promote and guarantee the health of women and newborns, regardless of the country, region, and character of the service (public or private).

CONCLUSION

Vaginal birth was more frequent, especially in younger women, classified as having usual or intermediate risk, admitted in the active phase of labor. Regarding obstetric practices in childbirth care, frequent interventions were found, such as the use of oxytocin, amniotomy, repeated vaginal exams, episiotomy, among others; the presence of a companion and food intake during the labor and delivery period were not guaranteed for all women, due to data integration; furthermore, from the statements, it was noted that the parturient was transferred to the delivery room/table and lithotomy position to give birth, commonly carried out by health professionals.

Therefore, the frequent use of harmful, ineffective, or inappropriately used practices and the scarce adoption of practices that should be encouraged in childbirth care were identified. Women aged less than or equal to 19 years were those who had the most vaginal births.

The need to strengthen the use of good practices is stated, opting to use obstetric interventions only when and if necessary. Because the birth was mainly accompanied by doctors, midwives must be included in the field of work. The inclusion of these professionals is believed to favor the use of good practices in childbirth care.

ACKNOWLEDGMENTS

To the National Council for Scientific and Technological Development (CNPq), Universal Call 01/2016, for research funding.

REFERENCES

1. Osis MJMD. Paism: um marco na abordagem da saúde reprodutiva no Brasil. Cad. Saúde Pública. [Internet] 1998 [acesso em 2023 Nov 17];14:S25–32. doi: https://doi.org/10.1590/S0102-311X1998000500011

2. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Política nacional de atenção integral à saúde da mulher: princípios e diretrizes / Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. – Brasília: Ministério da Saúde, 2004. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/politica_nac_atencao_mulher.pdf.

3. Leal MC, Szwarcwald CL, Almeida PVB, Aquino EML, Barreto ML, Barros F, et al. Saúde reprodutiva, materna, neonatal e infantil nos 30 anos do Sistema Único de Saúde (SUS). Ciênc. Saúde Colet. [Internet] 2018 [acesso em 2023 Nov 17];23(6):1915–28. doi: https://doi.org/10.1590/1413-81232018236.03942018

4. Santana TDB, Silva GR, Nery AA, Martins Filho IE, Vilela AB. Avanços e desafios da concretização da política nacional da saúde da mulher: uma revisão de literatura. Rev. Aten. Saúde. [Internet] 2019 [acesso em 2023 Nov 17];17(61):135-141. doi: 10.13037/ras.vol17n61.6012

5. Gama SGN, Thomaz EBAF, Bittencourt SDA. Avanços e desafios da assistência ao parto e nascimento no SUS: o papel da Rede Cegonha. Ciênc. Saúde Colet. [Internet] 2021 [acesso em 2023 Nov 17];26(3): 772. doi: https://doi.org/10.1590/1413-81232021262.41702020

6. Paraná. Secretaria de Estado da Saúde do Paraná (SESA-PR). Linha Guia-Programa Rede Mãe Paranaense. Curitiba: [s.n], 2022. 82 p. Disponível em: https://www.saude.pr.gov.br/sites/default/arquivos_restritos/files/documento/2022-03/linha_guia_mi-_gestacao_8a_ed_em_28.03.22.pdf

7. World Health Organization. WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: World Health Organization, 2018 [cited 2019 Aug 7]. Available from: https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf

8. Brasil. Ministério da Saúde. Departamento de Gestão e Incorporação de Tecnologias em Saúde; Secretaria de Ciência, Tecnologia e Insumos Estratégicos. Diretrizes nacionais de assistência ao parto normal: versão resumida. Brasília: Ministério da Saúde; 2017.

9. Menezes FR, Reis GM, Sales AAS, Jardim DMB, Lopes TC. O olhar de residentes em Enfermagem Obstétrica para o contexto da violência obstétrica nas instituições. Interface comun. saúde educ. [Internet] 2020 [acesso em 2023 Jul 1];24:e180664. doi: https://doi.org/10.1590/Interface.180664

10. Pinto KRTF, Zani AV, Bernardy CCF, Rossaneis MA, Rodrigues R, Parada CMGL. Factors associated with obstetric interventions in public maternity hospitals. Rev. Bras. Saúde Mater. Infant. [Internet] 2020 [acesso em 2023 Nov 17];20(4):1081–1090. doi: https://doi.org/10.1590/1806-93042020000400009

11. Martinez EML, Saez ZA, Sanchez EH, Camacho M. Métodos de proteção perineal: conhecimento e uso. Rev. Esc. Enferm. USP. [Internet] 2021 [acesso em 2023 Jun 12];55:e20200193. doi: https://doi.org/10.1590/1980-220X-REEUSP-2020-0193

12. Hidalgo-Lopezosa P, Cubero-Luna AM, Jiménez-Ruz A, Hidalgo-Maestre M, Rodríguez-Borrego MA, López-Soto PJ. Association between Birth Plan Use and Maternal and Neonatal Outcomes in Southern Spain: A Case-Control Study. Int. J. Environ. Res. public health [Internet] 2021 [acesso em 2023 Jun 11];8;18(2):456. doi: 10.3390/ijerph18020456. PMID: 33430039; PMCID: PMC7828065.

13. Oliveira GC, Braga EV, Galvão EL, Guedes HM. Associação entre a via de parto e o perfil obstétrico de parturientes. Enferm. foco [Internet] 2022 [acesso em 2023 Ago 11];13:e-202227. doi: https://doi.org/10.21675/2357-707X.2022.v13.e-202227

14. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14. ed. São Paulo: Editora Hucitec, 2014.

15. Leal MC, Bittencourt SA, Esteves-Pereira AP, Ayres BVS, Silva LBRA A, Thomaz EBAF, et al. Avanços na assistência ao parto no Brasil: resultados preliminares de dois estudos avaliativos. Cad. Saúde Pública [Internet] 2019 [acesso em 2023 Abr 18];35(7):e00223018. doi: https://doi.org/10.1590/0102-311X00223018

16. Antunes MB, Gravena AAF, Luz GS, Rissardo LK, Bolsoni LLM, Charlo PB, et al. Fatores sociodemográficos e condições de risco em gestantes de um ambulatório especializado do sul do Brasil. Revista Eletrônica Acervo Saúde [Internet] 2020 [acesso em 2023 Jun 21];38: e1985-e1985. doi: https://doi.org/10.25248/reas.e1985.2020

17. Carvalho ER, Nogueira RA, Marques AG, Marcon SS, Milani RG. Expectativa e experiência do processo parturitivo em mulheres atendidas em unidade básica de saúde. Saud e Pesq. [Internet] 2019 [acesso em 2023 Jun 14];12(3): 545-554, e-ISSN 2176-9206. doi: https://doi.org/10.17765/2176-9206.2019v12n3p545-554

18. 18.Monteiro BR, Souza NL, Silva PP, Pinto ESG, França DF, Andrade ACA, et al. Health care in the prenatal and childbirth context from puerperal women's perspective. Rev. Bras. Enferm. [Internet] 2020 [acesso em 2023 mar 10];73(4):e20190222. doi: http://dx.doi.org/10.1590/0034-7167-2019-0222

19. Pereira JTMO, Canario MASS, Zani AV, Bernardy CCF, Cardelli AAM, Pimenta RAF. Obstetric care in public maternity hospitals: comparative analysis of two cohort studies. Ciênc. cuid. saúde. [Internet]. 2022 [cited 2023 Nov 21]; 200. doi: 10.4025/ciencuidsaude.v20i0.58622

20. Paraná. Assembleia Legislativa do Estado do Paraná. Lei nº 20.127 de 15 de janeiro de 2020 que institui a Lei que garante à gestante o direito a escolher o tipo de parto no Paraná [Internet] 2020 [acesso 2023 mar 29]. Avaliable from: http://portal.assembleia.pr.leg.br/modules/mod_legislativo_arquivo/mod_legislativo_arquivo.php?leiCod=52034&tipo=L&tplei=0

21. Medina ET, Mouta RJO, Carmo CN, Filha MMT, Leal MC, Gama SGN. Boas práticas, intervenções e resultados: um estudo comparativo entre uma casa de parto e hospitais do Sistema Único de Saúde da Região Sudeste, Brasil. Cad. Saúde Pública [Internet] 2023 [acesso em 2023 Jun 19];39(4):e00160822. doi: https://doi.org/10.1590/0102-311XPT160822

22. Pereira SB, Diaz CMG, Backes MTS, Ferreira CLL, Backes DS. Boas práticas de atenção ao parto e ao nascimento na perspectiva de profissionais de saúde. Rev. Bras. Enferm. [Internet] 2018 [acesso em 2023 Jun 2];71(suppl 3):1393-9. doi: https://doi.org/10.1590/0034-7167-2016-0661

23. Santana AT, Felzemburgh RD, Couto TM, Pereira LP. Atuação de enfermeiras residentes em obstetrícia na assistência ao parto. Rev. Bras. Saúde Mater. Infant. [Internet] 2019 [acesso em 2023 Jul 8];19(1):135-44. doi: https://doi.org/10.1590/1806-93042019000100008

24. Parada CMG de L. Women's health during pregnancy, childbirth and puerperium: 25 years of recommendations from international organizations. Rev. Bras. Enferm. [Internet]. 2019Dec;72:1–2. doi: https://doi.org/10.1590/0034-7167-2019-72suppl301

25. Hatamleh R, Abujilban S, Abuhammad S. The effects of a childbirth preparation course on birth outcomes among nulliparous Jordanian women. Midwifery. [Internet] 2019 [acesso em 2023 Jul 11];72:23-9. doi: https://doi.org/10.1016/j.midw.2019.02.002

26. Teixeira SVB, Silva CFCS, Silva LR, Rocha CR, Nunes JFS, Spindola T. Experiences on the childbirth process: antagonism between desire and fear. Rev. Pesqui. [Internet] 2018 [acesso em 2023 Abr 12];10(4):1103-10. doi: 10.9789/2175-5361.2018.v10i4.1103-1110

27. Junges CF, Brüggemann OM. Factors associated with support provided to women during childbirth by companions in public maternity hospitals. Texto & contexto enferm. [Internet] 2020 [acesso em 2023 Jun 11];29:e20180239. doi: https://doi.org/10.1590/1980-265X-TCE-2018-0239

28. Melo LP, Pereira AM, Rodrigues DP, Dantas SLC, Ferreira ALA, Fontenele FM, et al. Representações de puérperas sobre o cuidado recebido no trabalho de parto e parto. Av. enferm. [Internet] 2018 [acesso em 2023 Jun 12];36(1):22-30. doi:10.15446/av.enferm.v36n1.63993