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NORMAL CHILDBIRTH CARED FOR BY OBSTETRIC NURSES: BIRTHING POSITIONS AND THE RELATIONSHIP WITH SPONTANEOUS PERINEAL LACERATIONS

PARTOS NORMAIS ASSISTIDOS POR ENFERMEIRAS OBSTÉTRICAS: POSIÇÃO MATERNA E A RELAÇÃO COM LACERAÇÕES PERINEAIS ESPONTÂNEAS

PARTO ASISTIDO POR ENFERMERAS OBSTÉTRICAS: POSICIÓN MATERNA Y RELACIÓN CON LACERACIONES PERINEALES ESPONTÂNEAS

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ABSTRACT

Objective: to assess the relationship between birthing positions and the occurrence of spontaneous perineal lacerations in women cared for in a birthing center. **Method:** retrospective study with a sample of 164 birthing records of a birthing center in 2014. The observed variables were sociodemographic, obstetric, and neonatal data. The analysis was carried out by the calculation of absolute and relative frequencies. **Results:** the most adopted position was upright (84.8%) and there was an occurrence of 86% of spontaneous lacerations, 50.3% of first degree, 45.4% of second degree, and 4.3% of third degree. **Conclusion:** the adoption of upright positions may have influenced the fewest number of complications and women satisfaction, because they had a positive childbirth experience. **Descriptors:** Care Humanization; Obstetric Nurses; Natural Childbirth; Patient Positioning; Perineum.

RESUMO

Objetivo: verificar a relação entre o posicionamento no parto vaginal e a ocorrência de lacerações perineais espontâneas em mulheres assistidas em uma casa de parto. **Método:** estudo retrospectivo com amostra de 164 prontuários de partos realizados no ano de 2014 em uma casa de parto. As variáveis observadas foram dados sociodemográficos, obstétricos e neonatais. A análise realizou-se por meio do cálculo de frequências absolutas e relativas. **Resultados:** as posições mais adotadas foram as verticais (84,8%) e no total ocorreram 86% de lacerações espontâneas, 50,3% foram de 1º grau, 45,4% de 2º grau e 4,3% representaram as de 3º grau. **Conclusão:** a adoção de posturas verticalizadas pode ter influenciado no menor número de complicações e na satisfação das mulheres por terem uma experiência positiva de parto. **Descritores:** Humanização da assistência; Enfermeiras Obstétricas; Parto Normal; Posicionamento do Paciente; Períneo.

RESUMEN

Objetivo: verificar la relación entre la posición en el parto vaginal y la aparición de laceraciones perineales espontáneas en mujeres atendidas en un centro de partos. **Método:** estudio retrospectivo con una muestra de 164 prontuarios médicos de partos realizados en 2014 en un centro de partos. Las variables observadas fueron datos socio-demográficos, obstétricos y neonatales. El análisis se realizó mediante el cálculo de frecuencias absolutas y relativas. **Resultados:** la posición más utilizada fue la vertical (84.8%) con 86% de laceraciones espontáneas, 50.3% de primer grado, 45.4% de segundo grado y 4,3% tercer grado. **Conclusión:** la adopción de posturas verticales puede haber influido en el menor número de complicaciones y la satisfacción de las mujeres, por tener una experiencia positiva del parto. **Descriptor:** Humanización de la atención; Enfermeras Obstétricas; Parto Natural; Posición del Paciente; Perineo.

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INTRODUCTION

In Western obstetrics of the 17th century, the phenomenon of upright birthing position took place along with the process of medicalization and institutionalization of childbirth in hospitals with the emergence of obstetric surgeons and the marginalization of midwives in obstetric care. For a long time, it was believed that the upright position was most suitable because it facilitated obstetric interventions, such as the study of the delivery mechanism, continuing cardiotocographic monitoring, induction of labor, administration of analgesia, and use of surgical instrumentation.^{1,2}

Studies claimed that non-Western women preferred upright positions throughout labor. This preference was due to the fact that these positions would bring more advantages, both from the gravitational point of view, by reducing the period of expulsive efforts, and the increase in maternal pelvic diameters, when compared with the supine position during labor.¹⁻⁵

Other advantages are that women in upright position exhibit more intense and efficient uterine contractions and expulsive efforts, in addition to lower risk of vulvar edema, severe pain, and obstetric interventions (episiotomy and instrumental delivery), compared with lithotomy.^{9,17} Still, this position is related to better fetal hemodynamic effects by reducing aortocaval compression and, consequently, increased pH of the umbilical artery, oxygen saturation, and cardiofetal beats.^{1-3,5}

The World Health Organization (WHO) has provided directives to promote procedures for safe and quality normal vaginal delivery, highlighting the importance of freedom of position during labor and encouraging women to avoid supine positions. Pregnant women should adopt the position that is more comfortable for them, but the professionals that provide care should know the advantages and disadvantages of each position to better guide these women.^{1-7,4,6}

Natural labor provides great benefits to the women and their newborns (NB), because it is in accordance with the nature of the body and the time of fetal maturity. However, most women (approximately 85%) suffer some sort of perineal injury during the passage of the fetus through the vaginal canal. These injuries are due to several factors, which may be associated with maternal, fetal, institutional, and obstetric care conditions, as well as labor.^{5-8,10,11}

The lacerations can be classified according to their depth, namely: first degree, when they only harm the skin and/or the mucous membrane; second degree, when they affect the perineal muscles; and third degree, when they affect the anal sphincter. The latter are subdivided into: 3a - involvement of less than 50% of the thickness of the external anal sphincter; 3b - affect more than 50% of the thickness of the external anal sphincter; and 3c - rupture of the internal anal sphincter. In case of injury involving the rectal mucosa, the lacerations will be classified as fourth degree.^{9,10}

The evidence indicates that nulliparity predisposes women to trauma and perineal pain after childbirth, and there are no conclusive studies showing how to reduce spontaneous perineal laceration during vaginal birth.^{1,5,12} Even though numerous studies have assessed the prevalence and factors related to episiotomy, as well as surgical opening of the skin in the mucosa and muscles of the perineal region, the occurrence of spontaneous perineal lacerations has been scarcely addressed.^{8-10,12-15} It is believed that the routine procedure of episiotomy preserves the perineal muscles; however, several studies have proven that it is a forbidden practice, because it can aggravate the lacerations and even generate greater discomfort to the women.^{9,12-15}

The use of less invasive procedures aimed at protecting the perineum, such as: upright or side-lying positions during the period of expulsive efforts; perineal massage during pregnancy; use of herbal compresses; acupuncture; and hands-off management, in which the fetal disengagement should happen naturally without using the hands; and careful use of oxytocin, could lead to perineal integrity and prevention of postpartum complications.^{6,8,10,12,15,16} The adoption of such measures requires changes in the care model and training of professionals who wish to work in obstetrics. Therefore, the movement in favor of childbirth humanization arises from this demand and allows women to resume their starring role in childbirth.^{2,7,15}

The Ministry of Health, together with other non-governmental organizations, has sought to promote natural childbirth, encouraging the performance of obstetric nurses in the birthing scene, so that women can be entirely cared for according to their biological, psychological, and spiritual dimensions. This policy was fundamental to the reconfiguration of the new obstetric model together with desmedicalization during labor and the performance of the minimum number of

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interventions during labor and childbirth. It is through this model that obstetric nurses stand out and distinguishes from the majority of the professionals in the obstetric field.^{7,16} In this context, the Ordinance 985/611 of the Ministry of Health, which establishes the creation of natural childbirth centers, defines them as health units that provide quality humanized care for normal childbirth without dystocia, which requires low complexity and technology.¹⁷

The current Ordinance No. 11 of 7th January 2015 redefines the guidelines for the establishment and licensing of natural childbirth centers within the Unified Health System, in order to provide care to pregnant women and NBs during labor and childbirth. This Ordinance complies with Rede Cegonha, which consists of a child care network aimed at ensuring women the right to reproductive planning and humanized care for pregnancy, childbirth, and puerperium At the same time, it assures children the right to a safe birth, growth and healthy development.^{18,19}

OBJECTIVES

The goals of the present study were:

- To identify the relationship between birthing positioning and the occurrence of spontaneous perineal lacerations in women cared for at a birthing center.
- To describe maternal and neonatal data.
- To identify the frequency and degree of perineal lacerations caused during births.

METHOD

This is a retrospective, cross-sectional, descriptive study on data from women who were cared for by obstetric nurses and residents in obstetric nursing in a birthing center located in a metropolitan region of the Federal District (FD), Brasília, Brazil. This center was opened in 2001 due to increased local demand for healthcare for women and children, and was accredited in 2015 by the Ministry of Health as a normal childbirth center.¹⁸

This birthing center meets the protocol with WHO recommendations. This protocol includes: admitting the mothers with their chosen caretakers; promoting relief measures for physical and mental discomforts; guiding on the most comfortable positions during labor and childbirth; maintaining hydration (teas, juices, and broths); ensuring autonomy, privacy and safety; avoiding the use of amniotomy or oxytocin used with the purpose of inducing normal labor; performing any procedure only with the consent of the

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women; and stimulate early link between the binomial mother-child, among other recommendations.¹³

This institution offers 24-hour walk-in service. However, admission is restricted to women with: normal-risk at term pregnancy; cephalic presentation; complete prenatal care, excluding large multiparous and pregnant women with prior cesarean delivery; postdatism; ongoing infections; previous maternal complications; and previous obstetric complications.

The data were collected from secondary sources through simple convenience random sampling using medical records, normal childbirths records, and indicators of this birthing center from January to December 2014. The inclusion criteria were: data of primiparous women with normal-risk, single, and at term pregnancy and fetus alive (37 to 41 weeks); and with cephalic presentation.

The exclusion criteria were: previous labor data; infectious process in the area of the vulva, vagina, and perineum at the time of labor; complications/interventions during labor (induction of labor, episiotomy, epidural or spinal anesthesia, forceps, and caesarean); admission as a result of childbirth at home, on the street, or in the car; and charts and books of records with incomplete or illegible data.

The data were analyzed using univariate descriptive statistics through the calculation of absolute and relative frequencies. A database was created using a Microsoft Excel spreadsheet. The variables of the study analyzed included the following data: sociodemographic (maternal age and origin); obstetrical (parity, number of medical visits and location of prenatal care, birthing positions, and occurrence and degree of lacerations); and neonatal (cephalic perimeter [CP] and birth weight).

The research project was approved by the Research Ethics Committee of the Health Sciences Education and Research Foundation (FEPECS), under certificate CAAE 46763215.4.0000.5553. The project received a waiver of informed consent form in accordance with the provision of the National Health Council Resolution 466/2012 and its complementary norms.

RESULTS

In 2014, 424 births were recorded in the center assessed. After applying the exclusion criteria, the final sample was composed of 164 medical records. Table 1 shows that most women of the analyzed sample were aged less than 25 years (62.2%). The minimum age was

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15 and the maximum 41 years. Approximately, 98% of the records belonged to primiparous women. With respect to the number of prenatal visits, more than half of the women (54.9%) had attended eight to eleven visits, followed by women who had attended four to seven visits (37.2%). The average number of

visits was eight prenatal visits, which was a greater number than the minimum number established by Rede Cegonha, since 85.4% of the women had attended prenatal care at the Unified Health System, and only 14.6% at the additional network.

Table 1. Sociodemographic and obstetrical data of the parturient women. Brasília (FD), Brazil, 2014. (n = 164)

Variables	No.	%
Age groups		
15 - 19 years	44	26.8
20 - 24 years	58	35.4
25 - 29 years	36	22
30 - 34 years	22	13.4
35 - 39 years	3	1.8
40 - 44 years	1	0.6
Parity		
1 pregnancy	160	97.6
2 pregnancies - 1 abortion	4	2.4
Prenatal		
0 - 3 visits	1	0.6
4 - 7 visits	61	37.2
8 - 11 visits	90	54.9
12 or more visits	12	7.3
Prenatal sector		
Public	140	85.4
Private	24	14.6
Total	164	100

Regarding the origin of these women, it was observed that the administrative region with highest prevalence was São Sebastião, State of São Paulo (61.6%). The prevalence of the other 18 administrative regions recorded was around 0.6 to 3%, i.e., little representative separately. There were also records of women from other cities of the State of Goiás (6.1%), and only one woman from the State of Minas Gerais.

Table 2 presents the obstetrical data of women cared for in the birthing center. The chosen birthing position that stood out was upright (84.8%). As to the number of spontaneous lacerations, 50.3% were classified as first degree, followed by 45.4% of second degree, and about 5% of third degree. There was 14% of women with no lacerations.

Table 2. Obstetrical data of parturient women. Brasília (DF), Brazil, 2014. (n = 164)

Variables	n	%
Birthing positions		
Upright	139	84,8
Lying	25	15,2
Lacerations	141	86,0
1° degree	71	50,3
2° degree	64	45,4
3° degree	6	4,3
Intact perineum	23	14,0
Total	164	100

Table 3 shows the relationship between spontaneous lacerations and the chosen birthing position. When the variables were correlated, it was possible to observe that the positioning of the women during labor might affect the occurrence and the degree of lacerations. The semi-sitting position was the most prevalent (33.5%), followed by sitting position (25.6%), and side-lying position (13.4%). Only the first position mentioned and all-fours position caused a higher occurrence of first-degree lacerations (49.1 and 50%) than

second-degree lacerations (32.7 and 37.5%, respectively).
In the side-lying position, the occurrence rate of third-degree lacerations was the highest (9.1%). However, the smallest number of lacerations occurred in this positions, 22.7% of the women remained with intact perineum. Second-degree lacerations were more recurrent in women sitting in a bathtub (52.9%) and squatting (66.7%). The best indexes with respect to perineal integrity and low-degree laceration shown in Table 3 were related to semi-sitting position (65.5%), all

fours position (62.5%), and side-lying position (54,5%).

Table 3. Relationship between birthing positions and the frequency and degree of spontaneous lacerations. Birthing Center, Brasília (DF), Brazil, 2014. (No. = 164)

Variables	Without lacerations n = 23		1 st degree n = 71		2 nd degree n = 64		3 rd degree n = 6		Total n = 164	
		%		%		%		%		%
Upright position	19	13,7	67	40,2	65	46,8	5	3,6	139	84,8
Standing	0	0	1	100	0	0	0	0	1	0,6
Semi-sitting	9	16,4	27	49,1	18	32,7	1	1,8	55	33,5
Sitting	0	0	1	50,0	1	50,0	0	0	2	1,2
Sitting in a bathtub	1	5,9	6	35,3	9	52,9	1	5,9	17	10,4
Sitting in a chair	6	14,3	16	38,1	18	42,9	2	4,8	42	25,6
All-fours	2	12,5	8	50,0	6	37,5	0	0	16	9,8
Squatting	0	0	2	33,3	4	66,7	0	0	6	3,7
Lying position	5	20,0	10	40,0	8	32,0	2	8,0	25	15,2
Side-lying	5	22,7	7	31,8	8	36,4	2	9,1	22	13,4
Supine	0	0	3	100	0	0	0	0	3	1,8

With respect to neonatal data, Table 4 shows that the most prevalent weight ranged between 3,001 and 3,500 grams (54.3%), followed with a certain representativeness by weight between 2,501 and 3,000 grams (23.8%), and between 3,501 and 4,000 grams (21.3%). In this way, the overall average weight of NBs was 3,220 grams. As for the assessment of CP, the highest occurrence was 34 cm, and the vast majority of PC measures was between 34 and 36 cm (66,5%).

Table 4. Relationship between neonatal data and spontaneous perineal lacerations. Brasília (DF), Brazil, 2014. (n = 164)

Variables	Without laceration n = 23		1 st degree n = 71		2 nd degree n = 64		3 rd degree n = 6		Total n = 164	
		%		%		%		%		%
Newborn weight										
2,000 - 2,500 g	0	0	1	100	0	0	0	0	1	0.6
2,501 - 3,000 g	10	25.6	15	38.5	14	35.9	0	0	39	23.8
3,001 - 3,500 g	10	11.2	43	48.3	34	38.2	2	2.2	89	54.3
3,501 - 4,000 g	3	8.6	12	34.3	16	45.7	4	11.4	35	21.3
Cephalic perimeter										
31 - 33 cm	10	20	22	44	17	34	1	2	50	30.5
34 - 36 cm	12	11	48	44	45	41.3	4	3.7	109	66
37 cm or more	1	20	1	20	2	40	1	20	5	3

Table 4 also presents a comparison between neonatal data (weight and CP) and lacerations. First-degree lacerations stood out, and first- and second-degree lacerations exhibited almost the same percentage. It was observed that there was a higher number of second- and third-degree lacerations in NBs weighting between 3,501 and 4,000 grams, and with CP greater than or equal to 37 cm.

DISCUSSION

In the present study, we observed that the women had their first pregnancy aged less than 25 years. This fact has been confirmed by other studies, according to which the majority of the Brazilian population has the first child at childbearing age (between 21 and 24 years).^{8,11,14,20,21} In 2014, 47.2% of primiparous women had their childbirth cared for in birthing centers. In other institutions, this number ranged from 23.6 to 55%.^{10,14,20}

It is believed that nulliparous women have greater chance of suffering lacerations due to less distensible pelvic floor, especially those women who are at extreme maternal age (under 18 and over 35 years). However, there is no direct relationship between perineal trauma and maternal age.^{8,10,23}

Prenatal visits accounted for a significant number in the present study. We observed that 62.2% of the women had attended eight or more visits. This result is in line with that of another study conducted in Rio de Janeiro in 2008 and 2009, which found that 66% of women had attended seven visits or more.²⁰ Prenatal care is the ideal time to offer appropriate guidance regarding the pregnant-puerperal cycle, in addition to make women aware of their rights.¹⁶

Most of the primiparous women had perineal lesions (86%), and most of them were first-degree lesions, which is in line with the

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findings of other studies.^{5,9,10} In addition, more than half of the women (57.3%) did not have lacerations, or exhibited low-degree lacerations. Although frequent, spontaneous lacerations are mostly shallow and easy to resolve, invading less tissue and, hence, leading to fewer complications than lacerations induced by episiotomy.^{9,12-15} The obstetric nurses of the birthing center assessed had based their practices in scientific evidence that did not indicate benefits of the routine episiotomy practice.

Regarding the degree of spontaneous lacerations, most women cared for in a birthing center of Rio de Janeiro exhibited first-degree lacerations (63.0%), followed by women with intact perineum (21.2%), and 12.4% with second-degree lacerations, without the occurrence of severe lacerations (third and fourth degrees).²⁰

The rate of these lesions was also considerably higher than that found by other study conducted with 166 primiparous women who had 62% of lacerations, 37.4% of first degree, 23.4% of second degree, and only 1.2% of third degree, also without the occurrence of fourth-degree lacerations.⁵ This difference was even greater in other two studies, with first-degree lacerations ranging from 72.5 to 82.4%, and second-degree lacerations ranging from 17.6 to 27.3%.^{14,21}

Second-degree lacerations are more prevalent in upright position, as was observed in the present study.³ These lesions are associated with short-term complications, which include blood loss, edema, hematoma, pain, dehiscence, infection, vaginal burning while urinating, and long-term complications due to more serious lesions, i.e., dyspareunia, urinary and fecal incontinence, and rectal fistula.^{5,7,16} Decreasing these consequences is a priority for women and the professionals who provide care to them. Information and training can promote better management of these conditions.^{15,23}

The risk factors of perineal trauma include: white skin color; Asian ethnicity; low maternal education; nulliparity; length of the perineum less than three centimeters; previous perineal scar; use of uterotonic drugs; supine position during labor; prolonged second stage of labor; directed expulsive efforts; and high weight and CP of the NBs, among others.^{9-12,14}

However, some factors related to labor, the mother, and the NB, such as: duration of the second stage of labor; type of expulsive effort; variety of positions in the cephalic detachment; umbilical cord around the baby's neck; and weight and CP of the NB did not influence the occurrence, the degree and the

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location of perineal lesions during vaginal childbirth according to other studies.^{8,21,23} These factors were observed in the present study regarding neonatal characteristics, such as weight and CP of the NBs.

On the other hand, the relationship between weight of the NB and intact perineum only exists when the weight is less than 3,150 grams, because, when the weight of the NB is greater than 3,300 grams, there is 1.6 times chances of causing second-degree lacerations.¹⁴ More perineal lacerations occur in deliveries of NBs weighing over 3,500 grams, especially those of second degree; however, with no statistically significant correlation between birth weight and the occurrence or degree of lacerations.⁸ Although revealed in the results of the present study, the association between weight of the NB and perineal trauma has to be assessed in further studies due to the divergence found in the literature.

A study conducted in Caxias do Sul, State of Rio Grande do Sul, found a greater prevalence of perineal trauma in NBs weighing 3,000 to 3,499 grams; however, without statistical significance. With respect to CP greater than 33 centimeters, there was a tendency of greater distention of the perineum that caused lacerations, but few studies have assessed this relationship.²³ In the present study, perineal integrity had a higher rate when the newborns weighed less than 3,001 grams and had a CP less than 33 cm; however, it was not possible to infer a consistent association between neonatal data and perineal lesions.

The use of resources, such as mothers' birthing positions, among other factors already described in the literature, may promote a higher frequency of low-degree lacerations.^{6,7,9,10} Upright and side-lying positions during labor and delivery are better than supine positions, because they are associated with the evolution of labor and maternal and fetal well-being.^{1,3,16,24}

In the present study, the position chosen by the women assessed was semi-sitting. However, it should be discouraged, because, in this position, the risk of vulvar edema and uterine bleeding above 500 mL increases after uterine emptying, and blood transfusion is not indicated.^{1,3} Probably, this position had been chosen due to a socio-cultural issue and not due to lack of guidance.

A study conducted in 2006 and 2007 in the city of Belo Horizonte, State of Minas Gerais, assessed 176 primiparous women and found that 55.4% of vaginal births had been in upright position and 44.6% in lying position.

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There was 50% of spontaneous perineal lacerations in women who had chosen the lying position at the time of childbirth, and 68% of lacerations in the upright position.⁵ The present study found that there was a higher number of childbirths with non-supine positioning (84.8%), and the difference was just 7% more lacerations in that position.

In another study also carried out in Rio de Janeiro, of 1,715 births cared for by obstetric nurses, the lying positions were the most chosen. Most of the women remained with intact perineum (63.2%), and the upright position obtained a higher score compared with the lying position. These results were not observed in the present study, since 14% of the women did not have lacerations, and the lateral decubitus positions had the highest percentage (22.7%).²⁴ However, regarding lying positions, if the lithotomy position at the time of delivery is avoided, there is less prevalence of perineal lesions in left lateral decubitus position.¹

With respect to the degree of laceration, the lateral decubitus position exhibited a much greater occurrence of first-degree lacerations (82.4%) compared to the occurrence of second-degree lacerations (17.6%) in a study conducted with 51 nulliparous women. In the present study, these values were very close, and a greater number of second-degree lacerations occurred in that position.⁸

Unfortunately, the preference for dorsal lithotomy position remains high. This fact may be due to lack of guidance during prenatal care, in-service training associated with the operative vaginal delivery (using forceps or vacuum extractor delivery, and episiotomy), and cultural aspects.¹ Few studies have assessed the profile of women who were in upright position during labor, and the relationship of these issues with positive obstetrical and neonatal outcomes.^{2,5}

Many studies have pointed out that the obstetric nurse is one of the most suitable professionals for monitoring normal-risk pregnancy and normal childbirth. Indeed, the results obtained in those studies revealed that the labors cared for by these nurses exhibited lower maternal and perinatal morbidity and mortality rates, number of cesarean sections, and other interventionist practices, in addition to promoting reduced hospital costs and improved care provided to these women.^{16,24} This results are in line with the care provided by the nurses of the institution assessed, who sought to provide an unmedicalized and humanized service.

In addition, freedom of position and movements, as well as the use of non-pharmacological methods for the relief of pain, are proven effective procedures and should be encouraged. These practices may include: slow breathing; muscle relaxation; comfortable environment; and the presence of the caretaker and the team of professionals that can promote a relationship characterized by support and safety, as is the case of obstetric nurses.²⁵

The great challenge of contemporary obstetrics is that some professionals should be aware that the routine and unnecessary performance of intervention alters the physiological course of childbirth and can trigger a cascade of events. One intervention leads to another in a successive way and, for that reason, obstetrical interventions should be judicious and based on evidence, and those that are only effective in high-risk groups should not be routinely performed.^{7,16}

Limitations of the present study can be pointed out, because it was a retrospective study based on the analysis of documents. In this model, it becomes difficult to control all the factors associated with perineal trauma, because there was a low number of procedures carried out in the birthing center assessed, and also due to the methodology used, which did not allow inferences, in addition to the existence underreported and incomplete data. Possibly, there were also biases in the classification of lacerations and identification of birthing positions.

CONCLUSION

The results of the present study revealed a high rate of perineal trauma in varied birthing positions; therefore, it was not possible to control all the risk factors that could aggravate the lacerations. However, it was evident that the women had mostly chosen lying and side-lying positions. This fact may have generated a lower rate of complications due to all the advantages relating to these positions already mentioned and, therefore, may have promoted greater women's satisfaction due to faster and peaceful childbirths.

We expect that the present study can serve as a basis for further studies in order to assess how birthing positioning and other humanized practices can contribute to consolidating the foundations of the care model sought by the WHO and the Ministry of Health. In addition, further studies are also needed to confirm whether the lithotomy position during childbirth contributes to perineal integrity, since the supine positions were barely

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observed in the present study and it was not possible to compare them effectively.

A change in the obstetric care model for normal-risk childbirth discourages labor in lying-position and medicalized, which is considered to be artificial and violent. At the same time, it encourages a minimum number of interventions during labor and upright positions, which are better suited for the physiology of childbirth by respecting the natural process of the body and the uniqueness of every parturient woman.

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