Women and Birth xxx (2017) xxx–xxx

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

Original Research - Qualitative

How obstetricians and pregnant women decide mode of birth in light of a recent regulation in Brazil

Rachel Galvao[a,*], Nicola L. Hawley[b], Carolina Silveira da Silva[c], Mariângela F. Silveira[d]

[a] Yale University, New Haven, CT, USA
[b] Department of Chronic Disease Epidemiology, Yale School of Public Health, New Haven, CT, USA
[c] Faculdade de Medicina, Universidade Federal de Pelotas, Pelotas, RS, Brazil
[d] Department of Maternal and Child Health, Faculdade de Medicina, Universidade Federal de Pelotas, Pelotas, RS, Brazil

ARTICLE INFO

Article history:
Received 26 July 2017
Received in revised form 7 November 2017
Accepted 29 November 2017
Available online xxx

Keywords:
Obstetrics
Pregnancy
Caesarean birth
Vaginal birth
Brazil

ABSTRACT

Background: In Brazil, 88% of births among women with private insurance are caesarean sections, even though a caesarean rate above 15% is associated with greater maternal and child morbidity and mortality. Aiming to reduce unnecessary caesarean sections in the private sector, in July 2015 the Brazilian government enacted Resolução Normativa 368, a regulation requiring the use of partograms, pre-natal cards to document pregnancies, and consent forms for elective caesareans, and recommending that obstetricians provide women with an informational letter about birth.
Aims: This study aimed to describe Brazilian women's experiences deciding their mode of birth and obstetricians' roles in this decision-making process after Resolução Normativa 368's enactment.
Methods: Interviews were conducted with obstetricians (n = 8) and women who had recently given birth (n = 19) in Pelotas, Brazil, and the constant comparative method was used to identify emergent themes.
Findings: Resolução Normativa 368's provisions do not appear to affect decision-making about birth mode. Reportedly, consent forms were rarely used, and were viewed as bureaucratic formalities. Obstetricians described consistent use of pre-natal cards and partograms, but all participants were unaware of informational letters about birth. Moreover, women viewed caesarean sections as a way to avoid pain, and obstetricians felt that vaginal birth's long duration, unpredictability, and low remuneration contribute to high caesarean section rates.
Conclusions: Improved enforcement of Resolução Normativa 368, accompanied by structural changes like an on-call schedule and higher compensation for vaginal births in the private sector, could better inform patients about modes of birth and incentivise physicians to encourage vaginal birth.

Statement of significance

Problem or issue

Little is known about how a recent regulation in Brazil might affect the process through which women and obstetricians choose birth mode, which is important information for developing policies to reduce high caesarean section rates.

What is already known

Conversations with obstetricians, fears of labour pain, and low risk perceptions of caesareans influence many Brazilian women towards having caesareans.

What this paper adds

Bureaucratic regulations may not be followed consistently and do not appear to affect the chosen mode of birth. There is a need for reform that provides time-related and financial incentives for obstetricians to encourage vaginal birth.

* Corresponding author at: 110 W. 39th Street, Apt. 609, Baltimore, MD 21210, USA.
E-mail address: rachel.galvao@yale.edu (R. Galvao).

https://doi.org/10.1016/j.wombi.2017.11.011
1871-5192/

1. Introduction

In Brazil, caesarean sections comprise 88% of births in the private sector and 46% in the public sector.[1] In light of the World Health Organization's statement that caesarean section rates above 15% can be detrimental to maternal and child health, Brazil's caesarean section rate is alarmingly high, especially in the private sector.[2] Caesarean sections can be life-saving procedures, but they also carry health risks. Caesarean sections without medical indications, compared with spontaneous vaginal births, are associated with increased risk of maternal morbidity and mortality, as well as adverse perinatal health outcomes.[3–5] A multi-country study from the World Health Organization's Global Survey on Maternal and Perinatal health found that caesarean sections without medical indications were associated with a higher risk of severe maternal outcomes such as hysterectomy, blood transfusion, intensive care unit admission, and death.[4] Medically unnecessary caesarean sections are also associated with severe perinatal outcomes, including fetal and neonatal death.[5] These risks indicate that Brazil's caesarean section rate, which is far above the recommended 15%, calls for public health concern.

Several studies have attempted to elucidate why caesarean sections are so common in Brazil. In a cross-sectional, survey-based study in the small urban centre of Pelotas, caesarean sections were associated with high maternal income and education level,[6] while interview-based studies in Pelotas, the large urban centre Porto Alegre, and the medium city of Natal, found that women's fears of labour pain and perceptions that caesarean sections represent higher quality medical care than vaginal birth may be contributing to their desire for caesarean sections.[7,8] However, these studies also suggested that physicians have an incentive to encourage women to have caesarean sections due to their predictable scheduling and shorter duration—45 min to an hour.[6,8]

Studies across various cities in Brazil have found that 66–72% of primiparous women who gave birth by caesarean in the private sector had initially wanted to give birth vaginally, which means that the high caesarean section rate does not necessarily reflect women's initial preferences.[8,9] As such, some women may end up having medically unnecessary caesarean sections due to pressure from physicians and inadequate doctor–patient communication.[8–10] For example, Hopkins interviewed 41 women, and found that even at the beginning of labour, some physicians made statements like the following: "You're one centimeter [dilated] now. I'm going to suggest to you that we do a caesarean. Do you want me to operate on you? Because it's just one centimeter. You're going to feel pain for I don't know how long."[8]

In light of these findings, the Brazilian government has sought to implement policies to lower caesarean section rates, particularly in the private sector, since the private sector caesarean section rate of 88% is nearly double that of the public sector.[1,11] In July 2015, Resolução Normativa n° 368 (RN 368) went into effect, requiring physicians to document a clinical justification for each caesarean section, utilise partograms, and provide women with prenatal cards as well as consent forms for elective caesarean sections.[12] A partogram is a tool used to document the progress of labour and determine if and when a medical intervention is necessary.[11] A prenatal card is a record of a woman's prenatal visits and tests, charting the course of her pregnancy.[11] The version of the prenatal card that is recommended (but not required) by the ANS contains an informational letter that describes the risks of elective caesarean section and the benefits of vaginal birth.[12] Thus, the regulation aims to hold physicians accountable for making medically informed decisions about birth procedures, but it also aims to encourage women to think carefully about the medical risks of elective caesarean section.

Although the existing literature has identified several factors associated with the high caesarean section rate in in Brazil, researchers have not yet examined women's experiences of birth decision-making in the context of this new regulation. Accordingly, we sought to understand how RN 368 affected obstetricians and women's birth decision-making and conversations surrounding mode of birth, if at all. We accomplished this through in-depth interviews that examined decision-making in the context of women's experiences with prenatal cards, consent forms, and interactions with their physicians, as well as obstetricians' experiences with their patients and the new procedural requirements. Findings from this study may help develop an understanding of the regulation's effect on how mode of birth is chosen, and could be useful to inform future policies to reduce unnecessary caesarean sections.

2. Methods

2.1. Study design and sample

This was a qualitative study of women who had recently given birth and obstetricians who serve private insurance patients in Pelotas, Rio Grande do Sul, Brazil. The private sector caesarean section rate in Pelotas, a city of approximately 340,000 people, is 84%, close to that of the nationwide private sector rate.[6,13] Participants were considered eligible for the study if they were either women with private health insurance who recently gave birth or obstetricians who served patients with private insurance. A qualitative approach was chosen to enable understanding of the nuances of physicians' and post-partum women's experiences of the decision-making process.

A combination of purposeful criterion sampling and convenience sampling was used to identify women who had recently given birth.[14] The first author (RG) went to the hospital's maternity ward several days per week, and nurses identified women with private insurance who had given birth in the past one or two days. This time frame was purposeful, given that proximity to the event would likely result in better recall of the decision making around mode of birth. Snowball sampling was used to identify obstetricians who served patients with private insurance.[14] The local project contact (an obstetrician and professor at the UFPEL medical school) recommended an obstetrician for the first interview, and each subsequent physician was asked for further interview subject recommendations. All interviews were conducted between late June and early August 2016. Sample size was determined by theoretical saturation, in which no new concepts emerged in successive interviews.[15] This occurred after 19 interviews with post-partum women and 8 physician interviews.

2.2. Data collection and measures

Post-partum women were invited to participate in person—the first author (RG), knocked on the doors of eligible patients' rooms in the maternity ward, briefly introduced herself as a student researcher interested in women's health, described the project, and invited their voluntary participation. A total of 22 women were invited to participate, and 19 (86%) agreed to be interviewed. The main reason indicated by women for non-participation was fatigue. Obstetricians were invited to participate through phone communication arranged by their administrative assistants. A total of 16 obstetricians were invited to participate, and 8 (50%) agreed to be interviewed. Physicians' schedules, travel, and personal illness were the main reasons given for non-participation. As a native Portuguese speaker, RG conducted all interviews in person. At the time of the study, she was an undergraduate student researcher in the Global Health Studies program at Yale University

Please cite this article in press as: R. Galvao, et al., How obstetricians and pregnant women decide mode of birth in light of a recent regulation in Brazil, Women Birth (2017), https://doi.org/10.1016/j.wombi.2017.11.011