The obstetrical and newborn profile of postpartum women in maternities in São Paulo

Santos, Jaqueline de Oliveira; Pacheco, Tuane Soares; Oliveira, Priscila Silva de; Pinto, Vania Lopes; Gabrielloni, Maria Cristina; Barbieri, Marcia

Federal University of Rio de Janeiro State

Journal of Research Fundamental Care Online

UNIRIO　PPgEnfBio　PPGENF

ISSN 2175-5361

DOI: 10.9789/2175-5361

RESEARCH

Perfil obstétrico e neonatal de puérperas atendidas em maternidades de São Paulo

The obstetrical and newborn profile of postpartum women in maternities in São Paulo

Perfil obstétrico y neonatal de madres atendidas en maternidades en São Paulo

Jaqueline de Oliveira Santos [1], Tuane Soares Pacheco [2], Priscila Silva de Oliveira [3], Vania Lopes Pinto [4], Maria Cristina Gabrielloni [5], Marcia Barbieri [6]

ABSTRACT

Objective: To describe the sociodemographic and obstetric profile of postpartum women in São Paulo, to check the perinatal data and to identify the type of delivery. **Method:** A descriptive, cross-sectional study involving 424 postpartum women. Data was collected through structured interviews and medical records. We used descriptive statistics for analysis. **Results:** There was a predominance of women between 21 and 30 years (60.6%), mulatto (55.2%), high school education (65.8%), without payment (57.3%), with a partner (85.4%), primiparous (34.9%) and without previous abortion (78.8%). The vaginal delivery was performed in 58.3% of women. Most newborns were male (52.2%), with appropriate weight and height (89.5% and 80.7%), and na Apgar score between eight and ten in the first minutes of life (> 90.0 %). **Conclusion:** There was a predominance of women with little education and unfavorable financial conditions, factors that hinder access to health services, contributing to increased maternal and neonatal morbidity and mortality. **Descriptors:** Women, Health profile, Health postpartum period.

RESUMO

Objetivo: Descrever o perfil sociodemográfico e obstétrico das puérperas atendidas em São Paulo, verificar os dados perinatais e identificar o tipo de parto realizado. **Método**: Estudo descritivo, transversal, realizado com 424 puérperas. Os dados foram obtidos por meio de entrevista estruturada e dos prontuários. Utilizou-se a estatística descritiva para a análise. **Resultados**: Constatou-se predomínio de mulheres entre 21 e 30 anos (60,6%), cor parda (55,2%), ensino médio (65,8%), sem remuneração (57,3%), com companheiro (85,4%), primíparas (34,9%) e sem aborto anterior (78,8%). O parto normal foi realizado em 58,3% das mulheres. A maioria dos recém-nascidos era do sexo masculino (52,2%), com peso e estatura adequados (89,5% e 80,7%), e Apgar entre oito e dez nos primeiros minutos de vida (>90,0%). **Conclusão**: Houve predomínio de mulheres com pouca escolaridade e condições financeiras desfavoráveis, fatores que dificultam o acesso aos serviços de saúde, contribuindo para o aumento da morbimortalidade materna e neonatal. **Descritores**: Saúde da mulher, Perfil de saúde, Período pós-parto.

RESUMEN

Objetivo: Describir el perfil sociodemográfico y obstétrico de mujeres recién paridas en São Paulo, comprobar los datos perinatales e identificar el tipo de parto. **Método:** Estudio descriptivo, transversal, que involucra 424 mujeres en el posparto. Los datos fueron recolectados a través de entrevistas estructuradas y registros médicos. Se utilizó estadística descriptiva para analizar. **Resultados**: Hubo un predominio de las mujeres entre 21 y 30 años (60,6%), mulatos (55,2%), de la escuela secundaria (65,8%), sin pago (57,3%), con un compañero (85,4%), primíparas (34,9%) y sin aborto anterior (78,8%). El parto vaginal se realizó en el 58,3% de las mujeres. La mayoría de los recién nacidos eran varones (52,2%), con peso y la altura adecuado (89,5% y 80,7%), y la puntuación de Apgar entre ocho y diez en los primeros minutos de vida (> 90,0 %). **Conclusión**: Se observó un predominio de mujeres con poca educación y las condiciones financieras desfavorables, factores que dificultan el acceso a los servicios de salud, contribuyendo al aumento de la morbilidad y mortalidad materna y neonatal. **Descriptores**: Mujeres, Perfil de salud, Período posparto.

[1]Nurse. Doctorate in Nursing. Associate Professor at Universidade Paulista. São Paulo (SP). E-mail: jaqueoliveira1@hotmail.com. [2]Nurse. Graduated from the Universidade Paulista. São Paulo (SP). E-mail: tuane_tuty@hotmail.com. [3]Nurse. Graduated from the Universidade Paulista. São Paulo (SP). E- mail: priscila_mazieri@yahoo.com.br. [4]Nurse. Administrative Technician of Education in the Department of Nursing in Women's Health at the Federal University of São Paulo. São Paulo (SP). E-mail: vania.lopes@unifesp.br. [5]Nurse.Doctorate in Nursing. Associate Professor, Department of Nursing in Women's Health at the Federal University of São Paulo. São Paulo (SP). E-mail: crisgabrielloni@unifesp.br. [6]Nurse. Doctorate in Nursing. Associate Professor, Department of Nursing in Women's Health at the Federal University of São Paulo. São Paulo (SP). E-mail: mbarbieri@unifesp.br.

INTRODUCTION

The 2010 Census, published by the Brazilian Institute of Geography and Statistics (IBGE), pointed to a historical trend of predominance of the female population in Brazil, indicating a ratio of 96 men for every 100 women in the present day, as a result of a surplus nearly 4 million women. It is estimated that by 2050 this number is over 7 million when compared to the male population.[1]

Considering the population size and the characteristics and needs of the female population, the Ministry of Health implemented the National Policy for Integral Attention to Womens Health (PNAISM), policies aimed at improving women's health in Brazil, consolidating advances in the field of reproductive and sexual rights in obstetric care, family planning, to combat violence against women, attention to unsafe abortion, prevention and treatment of gynecological cancers and sexually transmitted diseases as well as chronic non-communicable diseases.[2]

With the implementation of PNAISM there was an improvement in the indicators of women's health, such as reducing maternal mortality, which is a sensitive indicator of the quality of life of the population. According to the Ministry of Health, between 1990 and 2010 the Maternal Mortality Ratio (MMR) declined from 141 to 68 maternal deaths per 100 000 live births, representing a drop of 51%.[2]

However, delivery care in Brazil is predominantly characterized by hospitalization and interventionism, which translates into higher rates of cesarean sections, representing 44% of all births attended in the country and exceeding 80% in the private and supplementary[3] health system while the recommendation of the World Health Organization is 15%. According to the Ministry of Health, the realization of cesarean delivery in the country increased from 38.0% in 2000 to 52.3% in 2010.[2]

Compared to global rates, it is observed in the supplementary health sector, the number of cesarean sections performed in Brazil is more than many countries, like the United States, Portugal, Australia (30%), Italy, Mexico (33%), Slovakia, Norway and Sweden (14-18%).[4]

The model of care during labor and birth is a determinant of the health indicators of a population factor.[4] Therefore, to follow the trend and characteristics of obstetric care in municipalities and Brazilian health institutions is important for targeting of the main demands required by the health sector. Maternal characteristics such as age, education, occupation and marital status, and neonatal characteristics such as weight and length of gestation, as well as the mode of delivery, have influence on maternal and child health.[2]

It is also considered important to identify maternal and neonatal conditions in births in health institutions for proper planning of health care for this specific patient population in order to reduce morbidity and mortality and improving quality of care for this population.

Accordingly, the objectives of this study were to describe the sociodemographic and obstetric profile of postpartum women admitted to hospitals in the city of São Paulo (SP), to

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check the perinatal data and to identify the type of delivery more often used in the studied hospitals.

METHOD

A descriptive, cross-sectional study with a quantitative approach, developed in two hospitals of the public health system in São Paulo (SP). These institutions provide health care to the woman during labor process, assisted by doctors in an obstetric center, and during the postpartum period, in which the mothers remain hospitalized in a rooming unit, on average, for 48 hours after birth.

The population was composed of postpartum women assisted in the referred hospitals in the period of September-December 2012. Inclusion criteria were: age equal to or over 18 years, good general health, preserved cognitive and hearing ability with postpartum up to 48 hours, and admission in the Rooming Section (AC) in institutions selected for the study. Women who had complications during delivery or postpartum and those declined to participate were excluded. The sample consisted of 424 postpartum women who met the inclusion criteria, defined for convenience as to the availability of those to participate in the study.

Data collection occurred after the prior authorization of the maternities and approval of the research project by the Ethics Committee for Research in Humans of Paulista University, under number 75 280/2012.

Initially, women were approached by one of the researchers in their own quarter of the AC and then were invited to participate in the study, being informed about the nature and objectives of the study as well as the voluntary nature of their participation and ensuring of anonymity. After agreement, they signed the Free and Informed Consent form.

The interview and analysis of medical records were used as methods of data collection. We applied a structured questionnaire that was developed by the researchers themselves, to obtain information pertaining to sociodemographic (age, race, education, paid work activity and marital status) and obstetric profile of the puerperals (obstetric history, actual pregnancy evolution, gestational age, number of prenatal consultations, physical activity in the current pregnancy and mode of delivery). The data contained in medical records was used to supplement the information provided by the women and for collection of related profile data of the newborn (weight, height, sex and Apgar at first and fifth minutes of life).

The data were stored in a Microsoft Excel® software application. Descriptive statistical analysis was performed using SPSS, version 7.0 1, calculating the absolute and relative frequencies for all variables studied. To compare the type of delivery with maternal variables of interest (age, education, occupation, current gestational age, number of previous prenatal visits and type of previous delivery), we used the Squared Test and, where necessary, the Likelihood Ratio test. A significance level of 5% (p-value <0.05) was used.

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RESULTS E DISCUSSION

Study participants were 424 mothers all attended in the studied health facilities accommodations. The average age was equal to 26.4 ± 5.91 years, of mixed ethnicity (55.2%), with secondary education (65.8%) without paid work activity (57.3%) and companion with co-housing (84.2%), as shown in the data of Table 1.

Table 1 - Socio-demographic characterization of women giving birth. São Paulo (SP), 2012

Variables	n° *(f)*	%
Age group (years)		
18 to 20	71	16,7
21 to 25	149	35,1
26 to 30	108	25,5
31 tp 35	59	13,9
≥ 36	37	8,8
Skin color		
Mulatto	234	55,2
White	144	34,0
Negro	37	8,7
Indigenous	5	1,2
Yellow	4	0,9
Education *		
Illiterate	1	0,2
Elementary education	117	27,6
Secondary education	279	65,8
Higher education	19	4,5
Paid work activity		
No	243	57,3
Yes	181	42,7
Marital status		
With companion	362	85,4
With co-habitation	357	84,2
No co-habitation	5	1,2
No companion	62	14,6
Total	**424**	**100**

* Includes complete and incomplete education.

Regarding obstetric history of the puerperal women (Table 2), considering the current pregnancy and childbirth, it was found that 30.4% of women were primiparous, 34.9% had their first birth in period of data collection and 78 8% reported no history of abortion.

Table 2 - Distribution of women giving birth according to obstetric history.
São Paulo (SP), 2012

Variables	paragraph *(f)*	%
Number of pregnancies		
One	129	30.4
Two	119	28.1
Three or more	176	41.5
Number of births		
First	148	34,9
Second	131	30.9
Three or more	145	34.2
Previous abortions		
None	334	78.8
One	72	17.0
Two	12	2,8
Three or more	6	1,4
Tot	424	100

Through analysis of the data presented in Table 3, it was found that 98.3% of women had prenatal care during the current pregnancy, 68.6% had more than six visits and 93.6% of births occurred between 37 and 41 weeks of gestation (full term). The delivery mode achieved with the most frequency was the normal mode (58.3%). Among primigravidae, 55.8% (72) had normal deliveries and 44.2% (57) underwent cesarean section.

Table 3 - Pregnancy and obstetric data of the current delivery of postpartum women. São Paulo (SP), 2012

Variables	Nr. *(f)*	%
Prenatal consultation		
Yes	417	98.3
No	7	1.7
Number of pre-natal consultations		
None	7	1.7
1 to 3	19	4.5
4 to 6	107	25.2
> 6	291	68.6
Gestation		
Preterm	26	6.1
Term	397	93.6
Postterm	1	0.2
Type of delivery		
Regular	247	58.3
Cesarean	177	41.7
Total	424	100

Among women who delivered vaginally, 77.7% (192) had some type of perineal trauma, of which 46.2% (114) were episiotomy and 15.8% (39) laceration, from which 12.6% (31) first, 1.6% (4) second and 1.6% (4) third-degree.

Most women (75.0% - 318) reported not having practiced any physical exercise during the current pregnancy. Among those who performed physical activity (25.0% - 106), a light walk was reported as the primary (88.7%), followed by cardiovascular excercises (5.7%) and dance (3.8%). The practice of yoga and karate was practiced by only one woman (0.9% each).

In this study, we found no statistically significant difference between the type of delivery (normal or cesarean) and sociodemographic data of women, such as age (p = 0.1022), educational level (p = 0.5635) The remuneration (p = 0.4933), the current gestational age (p = 0.4005) and the number of prenatal visits currently performed (p = 0.6941). However, there was a statistically significant relationship between the type of previous delivery and the current birth, in which it was found that the greater the number of previous vaginal deliveries, the higher the percentage of women who gave birth in this way (p <0.0001) the same occurred with caesarean deliveries (p <0.0001).

Considering the profile of newborns, we found that the majority were male (52.2%), normal weight (89.5%), height between 45 and 50 centimeters (80.7%), good vital condition (Apgar score between 8 and 10) in the first minute (92.2%) and fifth minutes of life (98.2%), as shown in Table 4.

Table 4 - Characterization of newborns. São Paulo (SP), 2012

Variables	paragraph (f)	%
Gender		
Male	224	52.2
Female	205	47.8
Weight (grams)		
<2500	28	6.5
2500-4000	384	89.5
> 4000	17	4.0
Height (cm)		
<45	44	10.3
45 to 50	346	80.7
51 to 55	38	8.9
> 55	1	0.2
Apgar (1 minute)		
0 to 3	5	1.1
4 to 6	17	3.9
	12	2,8
8 to 10	395	92.2
Apgar (5 minutes)		
0 to 3	-	-
4 to 6	4	0.9
7	4	0.9
8 to 10	182	98.2
Tot	**429 ***	**100**

* Includes 4 cases of twins.

Identifying sociodemographic characteristics of postpartum women in Brazilian territory is one of the essential elements for the applicability of the by the Ministry of Health recommended actions for the humanization of birth care. This information allows the situational analysis of women attending health facilities in the region, enabling the healthcare team planning and implementation of health care specific to each territory.

Early identification of risk factors and classification of gestational risks require fast response and planning of care, resulting in the reduction of maternal and infant morbidity and mortality. Accordingly, certain individual sociodemographic characteristics and unfavorable conditions, such as below 15 and above 35 years of age, occupation, insecure marital status and poor education are classified as pregnancy risk factors.[5]

It was found in this study that the sociodemographic and obstetric profile of the mothers and newborns treated at two hospitals in the city of São Paulo, in general, were similar to those found in studies developed in the cities of Salvador (BA), Maringá (PR) and Serra (ES).[6-9]

Regarding the age of the participants, there was a predominance of women at a young age, especially between 21-30 years (60.6%). In the studies reviewed above, we identified the same age profile where the number of women at that age was greater than 60.0%.[6-9]

Regarding the education of the participants, the data from this study revealed that the majority (65.8%) studied until high school, which means study time between 9 and 12 years, whereas there was no repetition. A descriptive study with 53 women participating in a workshop of pregnant women in Curitiba study also showed that school profile (58.9%).[10] Research conducted in a Normal Birth Center (ANC) in São Paulo found that 66% of women treated in this institution from 2006 to 2009 studied for 8-11 years[11], while in the city of Salvador 54.8% of postpartum women in Single System de Saúde (SUS) studied for 10-12 years.[6]

The study period of less than five years is classified by the Ministry of Health as a pregnancy risk factor. In this sense, the predominance of women with a longer study period, as shown in these works, tends to lower the chance of developing serious morbidity and maternal death from preventable causes, since the higher maternal education, the higher the number of Prenatal queries are performed, a factor that increases the chance of early detection and treatment of diseases.[5]

Most participants (55.2%) declared themselves to mulatto skin. Descriptive study developed in Sierra with 1335 postpartum women found a similar feature (69.06%) [7], while in Salvador, among 449 women attended by the Public Health System (SUS), 47.9% considered themselves as black and 44.1% mulatto. [6] However, research held in São Paulo and Curitiba revealed predominance of white women, 60.4% and 84.9%, respectively.[10-11]

The Ministry of Health indicate that maternal deaths by direct obstetric causes in the period 2002 to 2006 were higher among mulatto, while the white and black women had the highest rates of maternal deaths due to indirect causes.[12] In addition, Black people are related to unfavorable socioeconomic position, the lower levels of education and greater difficulties in accessing health services[6.13], influencing the health status of the female population in Brazil.

Most postpartum women studied in the maternity wards mentioned not pursuing paid work activity (57.3%), similar results were found in studies conducted in hospitals in the cities of Salvador (55.7%) and[6] Maringa (66.2%). [8]In contrast, in São Paulo 62.9% of women received remuneration for their work. [11]The characterization of Brazilian women presented by Census 2010 indicated that 56.9% of them had received an income which averaged just over one minimum wage at the time (R$ 510.00).[2]

When compared to men, women face higher health care costs due to their increased use and greater likelihood of having minimum financial conditions, to be unemployed or performing precarious and informal work. [2]This situation may jeopardize the health of the woman especially during pregnancy and childbirth, resulting in difficulty in access to health services or work overload, factors that increase the possibility of maternal morbidity.

The low education is related to the difficulty of women entering the labor market, resulting in poor financial condition, which in turn, as mentioned above, can also compromise the quality of life and health status of women.[6]

Thus, it is essential that the health professional that attend to pregnant women are aware of the social and economic conditions of these women, with regard to the possibilities of complications related to these factors.

The safe marital status is considered by the Ministry of Health as a factor that reduces the chances of occurrence of pregnancy complications, indicating that the presence of the father must be stimulated during consultation and group activities to prepare the couple for labor. [5] In this study, it was found that 85.4% of participants have a companion, which can result in better prognosis for the fetus. [14]This finding was similar to those found in Salvador (79.1%) and Serra (71.46%). In a descriptive study in Maringa only 31.6% of the mothers had a companion contrasting to other studies.[6-8]

Regarding prenatal consultations, 68.6% of women had six or more consultations during pregnancy. These values were similar to data found in studies of maternity Maringa (63.6%)[8,] Serra (54.3%)[9] and of the CPN São Paulo (87.3%).[11]

A key indicator of prognosis at birth is prenatal care. Its goal is to ensure the development of pregnancy, allowing the birth of a healthy newborn with no impact on maternal health. According to the WHO and the Ministry of Health, the appropriate number of consultations to ensure the quality of care in this period would be less than 6.[5] In this sense, we found an adequate number of queries performed by the majority of women surveyed, resulting in lower maternal risks.

Considering the gestational age at delivery, 93.6% of births occurred between 37 and 41 weeks (term), similar to other studies.[7-11.15] The of preterm birth and low birth weight in children is a increased risk of death, especially in the neonatal period.[2]

The Ministry of Health indicates an increase in the proportion of cesarean deliveries in the country. In this study the number of normal births was higher than cesarean, but is still higher than that recommended by the WHO.[2]

Descriptive study of the historical series relating the rate of caesarean sections in Brazil according to sociodemographic characteristics indicated that women undergoing cesarean were 3.5 times more likely to die between 1992 and 2010 and five times more likely to develop puerperal infection between 2000 and 2011 than women who delivered

vaginally. Furthermore, the proportion of premature infants was greater in c-sections (7.8%) than in normal births (6.4%) in 2010.[2]

The Cegonha Network is a program proposed by the Ministry of Health as a strategy to change cesarean rates in the country, through the reorganization of the maternal and child care network, stimulating the deinstitutionalization of labor and low risk birth, which would be attended ANC in Peri or intrahospital with the midwife and/or obstetric nurse in the centrality of care.[2,5]

This strategy can help change the landscape of births in Brazil, however, this depends on how these proposals will be converted into actions and will be inserted into the everyday life of health services. It is believed that incentives for normal childbirth among the population contribute to the success of the Cegonha Network.[2,5]

Regarding the new born infants, a profile was found of predominantly male infants, with appropriate weight and height for a pregnancy to term time, and with good vital conditions. These characteristics represent the birth of children with better prognosis, indicating adequate care to women during their pregnancy and childbirth given by the studied hospitals.

CONCLUSION

We conclude that there was a predominance of young, primiparous women with little education and unfavorable financial conditions, and from newborns with good vital conditions. This information is important for planning health care directed at this population in line with the recommendations of the humanization of care.

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Contact of the corresponding author:
Jaqueline de Oliveira Santos
Rua Napoleão de Barros, 754
Vila Clementino, São Paulo(SP), 04024-002.