Journal of Nursing
Revista de Enfermagem
UFPE On Line
JNUOL
ISSN: 1981-8963

ORIGINAL ARTICLE

THE OBSTETRIC NURSE IN A PLANNED HOUSEHOLD BIRTH

O ENFERMEIRO OBSTETRA NO PARTO DOMICILIAR PLANEJADO

EL ENFERMERO OBSTÉTRICO EN PARTO HOGAR PLANEADO

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ABSTRACT

Objectives: to describe the challenges and obstacles in the nursing actions during the planned household birth and to reflect on the social and professional context experienced by the obstetric nurse in assisting the planned household birth. ***Methodology:*** descriptive and exploratory study with a qualitative approach, using the theoretical framework Theory Based on Data. The production data occurred from 22 interviews with obstetric nurses in five regions of Brazil. ***Results:*** the analysis of the results revealed three themes: << Cultural prejudice>>, << Professional attitude >> and << Lack of logistical support >>. ***Final remarks:*** The planned home birth with nurse assistance attends to health policy. However, the full realization of this practice still lacks specific resolutions to ensure access of the mother to the public health system, for private services or services linked to SUS, when it is necessary forward the mother. ***Descriptores:*** Home Childbirth; Humanized Birth; Obstetric Nursing.

RESUMO

***Objetivos*:** descrever os desafios e obstáculos na atuação do enfermeiro no Parto Domiciliar Planejado e refletir sobre o contexto social e profissional vivenciado pelo enfermeiro obstetra na assistência ao Parto Domiciliar Planejado. ***Metodologia*:** estudo descritivo-exploratório com abordagem qualitativa, utilizando o referencial teórico-metodológico Teoria Fundamentada em Dados. A produção de dados se deu a partir de 22 entrevistas com enfermeiros obstetras, em cinco regiões do Brasil. ***Resultados*:** na análise dos resultados emergiram três categorias temáticas: << Preconceito cultural >>, << Atitude profissional >> e << Falta de apoio logístico >>. ***Considerações finais*:** o parto domiciliar planejado assistido por enfermeiro atende a política de saúde. No entanto, a efetivação plena dessa prática ainda carece de resoluções específicas que garantam acesso da parturiente ao sistema público de saúde, aos serviços privados ou conveniados ao SUS, quando necessário de encaminhamento da parturiente. ***Descritores*:** Parto Domiciliar; Parto Humanizado; Enfermagem Obstétrica.

RESUMEN

Objetivos: describir los desafíos y obstáculos en las acciones de enfermería en los hogares de Planificación de Trabajo y reflexionar sobre el contexto social y profesional experimentado por la enfermera obstétrica en la asistencia a la Casa de Trabajo de Planificación. ***Metodología:*** estudio descriptivo y exploratorio con abordaje cualitativo, utilizando el marco teórico Teoría Sobre la base de datos. Los datos de la producción fueron de 22 entrevistas con parteras en cinco regiones del Brasil. ***Resultados:*** el análisis de los resultados revelaron tres temas: << Prejuicios culturales >>, << Profesional actitud >> y << Falta de apoyo logístico >>. ***Consideraciones finales:*** los nacimientos planificados en el hogar atendidos por la enfermera atiende a la política de salud. Sin embargo, la plena realización de esta práctica aún carece de resoluciones específicas para garantizar el acceso de la madre para el sistema de salud pública, a los servicios privados o asegurados al SUS, cuando sea necesario el enrutamiento de la madre. ***Descriptores:*** Parto en Casa; Parto Humanizado; Enfermería Obstétrica.

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INTRODUCTION

Childbirth is a moment of great changes for mother; however, autonomy and decision of their body at the time of giving birth to her son must prevail the women's will.[1] For many pregnant women the process of giving birth in the hospital context denotes a risk event, suffering, physical or symbolic violence, expectations and frustration, making it difficult to transform the delivery experience into something positive, rewarding and healthy.[2] In Brazil, widespread institutionalization of childbirth has led to the use of invasive technologies, high rates of cesarean, episiotomies, higher frequency of induction with oxytocin, misoprostol, and other behaviors which are considered unecessary.[2]

Humanizing the assistance to women during the delivery process points to attention to the woman and family in their uniqueness, with specific needs that go beyond biological questions and encompass social, ethical, educational and psychological conditions within human relationships.[3,4] The public health policy focuses on strengthening women front to identify their health needs, claim their rights in promoting self-care in order to improve the mother's quality of life and newborn.[4]

The obstetrician nurses when deploying the humanization practices recommended by the World Health Organization, in the attention to pregnant women, have begun to use techniques that consider favorable to the physiological evolution of labor and non-pharmacological approaches for relieving pain.[3] In the parturition process, the importance of scientific and technological advances in recent years are recognized, but it points to the rescue of the historical model of giving birth, so the home environment has returned again as a favorable place for childbirth. In this context, the obstetrician nurse emerges on the rise for planned home birth, [5] with practices culturally known less interventionist that allow physiological evolution of labor, and the residence is considered a safe, viable and healthy place for laboring women to give birth. [5]

In this understanding, the planned home birth presents a real option as a ransom to the physiological delivery model, historically compatible with the natural birth process. However, this approach requires a competent professional performance with procedures directed to the mother and her family, this form of assistance goes beyond the social challenges and different requirements from traditional delivery. According to this thought, this study aims to:

• To describe the challenges and obstacles in the nursing actions in Planned Home Childbirth;

• To reflect on professional and social context experienced by the obstetrician nurse in the care for home birth.

METHODOLOGY

This is a qualitative, exploratory and descriptive study, using as a methodological approach to Grounded Theory. Qualitative research allows investigating the reality that cannot be quantified, that is, it works with a universe of meanings, motives, beliefs, values, responding to a deeper space of relationships, processes and phenomena.[6]

The Grounded Theory aims to capture and interpretation of what happens in a given context or object studied, how is the day-to-day participants, and from the understanding of the meanings and implications, producing knowledge and providing direction relevant to action.[7]

The Grounded Theory aims to discover theories, concepts and hypotheses based on the data collected, instead of using those predetermined ones. This method allows the researcher to develop and relate concepts that describe how the participant lives a certain reality and how to face the challenges it presents, the researcher seeks to build a conceptual model to explain the study phenomenon.[7,8]

22 obstetrician nurses were interviewed, with only one male. Data collection took place between January and July, in 2012, in five regions of Brazil, in the states of Santa Catarina, Minas Gerais, Rio de Janeiro, São Paulo, Distrito Federal, Bahia, Ceará and Pará, where there are obstetrician nurses who work in Planned Home Childbirth. The semi-structured interview happened via internet – on Skype or Messenger, through voice chat. The sample of the subjects occurred by saturation data, the participants were identified by letters in alphabetical sequence. The project was approved by the Research Ethics Committee of the Pontifícia Universidade Católica of Goiás, registration nº 1887, 28/10/2011.

RESULTS

In analyzing the data, we elaborated three themes: <<Cultural Prejudice >>, << Professional attitude >> and << Lack of logistical support >>, according to the discourse of nurses who are at the forefront of

attention to planned home birth in Brazilian urban centers.

♦ Cultural Prejudice

Civil society and health professionals in the last three decades built paradigms about childbirth care that emphasize the advanced technology as a synonym for quality and safety. Changing the technicalities and interventional historical model to a practice that rescues the natural birth endowed with few technological devices represent major challenges in the assistance operations. Since the culturally models established over the years, in the imagination of people the ideal delivery corresponds to painless childbirth in hospital with a highly complex surgical procedures.

This vision of delivery care hinders the inclusion of autonomous nursing practice in the current healthcare system in the country, whether in the public or private services. The planned home birth is perceived as a throwback to more primitive society like denying women the progress of the advantages of modern medicine and socially sustained structures, according to the reports of the deponents there is prejudice, particularly of families, because pregnant women who want natural childbirth hide that will give birth at home:

> *Socially we have a problem that people do not understand the home birth. They think that it is a kind of cult. People do not understand the philosophy of a home birth. They think this is a setback. So, we already have the first barrier which is to overcome this social prejudice of home birth (I).*
>
> *[...] Because it has a whole prejudice, culture is the C-section, then the home birth is against the culture, there is a lot of prejudice, not only in the family, even the professionals, doctors, and professionals in my class, and the nurses as well (P).*
>
> *They do not want to know our work, they say they do not value us, but they cannot value a job that they do not know (B).*
>
> *In public opinion, it is completely unknown to the population, it is classified as craziness when you say you want to have your baby birth at home, it's almost the same thing to say: I want to kill him (the son), you are seen like a crazy person (D).*

Resistance by society certainly stems from the cultural process. But the interviewees reported that difficulty is overcome after the success of births at home, publications in scientific journals, interviews in newspapers, and speeches of their own customers who disclose their positive experience among their acquaintances and internet and social networking pages:

> *Here we seek to grow in research, we already have nurse with data from home deliveries to reveal as a scientific practice and show to academia to show that home births are as safe as hospital deliveries (G).*
>
> *On the internet site, we work a lot with the question of the interview in the newspapers; people and they (mothers) rather to talk to us to clarify who want a home birth [...] We tell the patients we have read about home birth and we're trying to work it on social networks, at hospital and also in the group. There is a general disclosure work to show what we do, we take equipment to show there is not that assistance that existed in the past (S).*
>
> *Our patients really disclose our work, sometimes new mothers come here by indication of others [...] they disclose their birth on the Internet and this reinforces our work (T).*

There is a cultural resistance to birth at home, by associating security to hospital, interventional and surgical birth. A paradigm built daily in the social and family behavior that certainly suffered influences of situations, media that induce society to dream and that the people to be happy and successful should be consumer of technologies, regardless of sacrificing the natural and biological functions human.

♦ Professional attitude

From the 60s, the birth becomes institutionalized focusing on interventional practices accompanied by hospital technology advances. Recently, the nursing has assumed the planned home birth. However, some medical professionals prefer natural childbirth; this approach is far from practice, considering the physiology of labor and birth as a long process of parturition, impeding the assistance from humanizing perspective.

Many respondents have reported they receive criticism from some doctors. When the nurse directs the mother in emergency cases to the hospital, it is not always well received. Certainly, the consequences of stigmatization of this practice could limit the work of obstetric nurses:

> *We are seen All the time in any maternity or wherever you know of our work. So we are accustomed with it and this does not affect us, but all the time we heard: oh, those girls! We work very carefully, very cautiously. I always talk with colleagues everything; we have to be well backed to be worded for those who speak against us (A).*
>
> *We also have too much trouble for lack of support in referrals. We do not support from public hospitals for callings and talk about the case of pregnant woman who is in labor at home when the mother gets there,*

already branded. Most referrals are made by the same emergency door (G).

Having a supportive doctor would be a challenge, because sometimes it is necessary to take application and something, so a medical partner for us is very difficult. Until now, there is not a pediatrician here who wants this bond with us to meet at home (H).

The lack of medical support in teams is overcome through informal partnership with some people who favor the practice of humanized delivery. Over time, many nurses have increased their professional contact network and their work became known by many obstetricians. And there is approach to health professionals who advocates natural childbirth that supports nurses when needed. But also, in many cases there is opposition to this practice and there was no possibility of formal partnership in the team.

We look for partnership. Despite having little support, some doctors that are conducive to normal delivery, in a way they support us (G).

We do not have doctors on staff, but we have obstetricians who support us, so when we need, we called these people who give us support (H).

We have a pediatrician, who in some cases of doubt, or when we need something, we called and he has helped us, but he has no connection with the home birth (H).

During prenatal there is a plan B, in case of dystocia or situations which might compromise minimally labor and prevent labor at home, the mother is forwarded to the referential maternity-hospital for birth. If the mother has a healthcare plan she will be forwarded to a private hospital according to her choice, and if she does not have insurance she will be referred to the public health.

Still according to statements, the care for the mother in the maternity often becomes confrontational experiencing various forms of subjective violence. Certain health professionals when receiving the customer, they stigmatize her for having joined a practice that is not culturally determined by the public health system:

When the woman opts for planned home birth, in the first visit the plan is done: if the couple prefers a referral to maternity - Plan A: public maternity, and plan B: private clinic (E).

The biggest challenge is when the home birth does not happen and the mother is taken to a hospital, suffers prejudice, as we also suffer the prejudice of our fellow nurses and medical class (E).

In private hospitals, when we have a regular doctor is very quietly, but when there is not this reference person and they (laboring women) go mainly for the public service they are abused, hear jokes, they cannot have a reference system (I).

The woman has the right to continuity of decent service, while our women here are humiliated, suffer all kinds of violence, just because she was trying homebirth [...] Then she is forced to go to a public institution where professionals do not respect their decision to try to give birth at home and they end often subjected even a verbal violence (P).

To avoid institutional conflict, the mother and companion omit what they were trying to homebirth. They justify that they were at home waiting for the evolution of birth:

To prevent institutional violence, our alternative in case of transfer or referral of the patient to the hospital, they do not talk that was trying homebirth (L).

We never talk we were trying home birth, I always say that we were expecting labor evolve to take to the hospital (N).

About the transfer process in a public hospital, the mother will enter by the emergency door and serviced according to the normal procedures. In a private hospital, the nurses come in contact with the doctor who will support the chosen hospital:

Over prenatal, references are thought, in case of a real emergency reference, I need the closest health facility that has obstetric care. So we all plan together with family (J).

Regarding the transfer, there is always a support, a rearguard doctor (P).

So, we have the options of obstetricians, who support and believe in our work and accompany this patient, if necessary (S).

Even with scientific evidence about the benefits of natural childbirth, there is veiled resistance from medical institutions regarding the participation of these professionals in childbirth in domicile, which further enhances the detachment of some doctors to support this practice. Doctors who support and participate in the planned home birth are also stigmatized by regulatory agencies of medical practice.

♦ **Lack of logistical support**

The obstetric nurse in labor and delivery at home, independent of the necessity for hospitalization, need logistical support of the health system for specific materials and medicines, which are restricted to hospitals. The difficulty for acquisition is a problem in everyday life of nurses. However, some respondents reported that can have access to inputs through contact with representatives of

products, sometimes mediated by doctors who facilitate the acquisition and other professionals who also attend childbirth at home and work in hospitals, so the purchase of medicines is facilitated by institutions managers:

> It is necessary material of support in the case of dystocia, such as a bleeding, to puncture a vein and direct the patient with some degree of security. In the case of newborns, to have basic support material(E).
>
> We need to have the oxytocin box, Methergin ampoule, not only pills, for now we can do it with the teams that know our work. But we cannot buy medicines. We are always trying, but until now we cannot buy it (A).
>
> Normally, I try a known doctor and ask him to prescribe. So, we ask the patient to buy it at drugstore (F).
>
> I always have friends who make contact with representatives to facilitate the acquisition. It's the only way to get it (N).

However, some interviewees reported that bureaucratic rigidity, even with the Declaration of Live Birth – DNV, there is resistance from the Registry requiring special guarantees to conduct the newborn registration process. Some nurses have registered at Department of Health Surveillance and had access to DNV for delivery care at home:

> We have no access to DNV. We have been to state and local health department. We went to Brasilia, but here we didn't get DNV. They say we have to be linked to an institution (H).
>
> The Department of Health has strongly supported our work. So we registered ourselves in the department, then we are entitled to DNV and the membership card (EI).
>
> I still feel difficulty for the newborn record. I made a delivery in February and even with DNV, the notary did not want to register... It is an absurd; I had to go there to witness it!!! (O)
>
> I've received five printed, and I filled it out, I did everything right and the notary questioned and asked for a witness [...] They created many problems to register us(C).
>
> Sometimes we still have difficulty in baby registry [...] Even we are registered in the health department and having access to DNV, there is always a problem at the time of recording (Q).

To overcome the newborn registration difficulties, the couple previously informs the notary they are interest in home birth assisted by a nurse. This attitude alone is not enough; the nurses make a printed report, and with birth data, their parents have to be witnesses to realize the registration. The coping strategies are developed as the emergence of the problems:

> *We do a printed delivery report; I always guide couples to go before the notary and notify wanting a home birth, so there is no doubt about the legitimacy of birth and sometimes we are witnesses for there is no doubt (A).*
>
> *We follow our patients to the registry, even when they are pregnant [...] and they stated that they want home birth and when the baby is born we witness, and they do the record (N).*

In addition to the regulation of distribution of health inputs, the professional also faces problems with some civil registry offices for the registration of the new citizen. In some regions, some interviewees reported not having access to DNV distributed by the Municipal Health. This obstacle reflects a limitation on the exercise of professional, nurses feel pressured to employment relationship with an institution, and this reaffirms the current paradigms of home birth. The difficulty of obtaining DNV puts unfairly the professional in a situation of apparent infringement, causing embarrassment for the professional front of the assisted client.

Although the registration of the newborn at home is a lengthy process, all babies got the Civil Registry, eliminating the possibility of underreporting record. In some situations, the nurses find a notary public that does not create obstacles and use this as a reference institution for the records of birth.

DISCUSSION

In the category Cultural Prejudice the study have revealed that cultural prejudice still prevails when pregnant women declare interest in realizing their home birth, from family, society in general and some health professionals. This practice has been described as a challenging aspect by both the pregnant couple and nurses.[5,9]

The operating time at work gives credibility among social and professional groups of obstetric area. Credibility was due to the fact that customers disclose their successful experience of home birth, informally among friends, family and even the media through social network. Professionals who work in the planned home birth were winning the appreciation of medical who agree with humanized birth practices. Since, in this care approach although there was referrals, there was not procedure to put the life of the mother or fetus at risk of morbidity and

mortality, all deliveries were sent in time for a safe hospital care.[9,10]

Culturally, the home birth is equivalent to leave the hospital safe and afford to give birth in an inappropriate and archaic environment, according to the design of civil society and health professionals.[5,9] This view is not consistent with research conducted in the United States and Canada, which evaluated 5,418 births for planned homebirth. From this total, only 12.1% mothers were transferred to hospital. Half people took place on their request, for pain relief. Between transfers in 1.3% occurred bleeding or placental retention. Only 3.4% were considered at a potential risk.[11]

The professional attitude revealed that in some Brazilian states, nurses who attend home births have informal contact with obstetricians that support professionals. Although they do not compose the work teams, they help in situations of transfers and monitoring the mother, especially when they need prescription of medications. Although it's not an official partnership, it just facilitates the process of attending women in birth.

In July 2012, the Regional Council of Medicine in the state of Rio de Janeiro (CREMERJ) issued Resolution 265/12, which banned the participation of the physician in home birth and participation of staff in support and guard, previously agreed. It determined which is reportable to CREMERJ, for Technical Directors and duty doctors of hospitals, the assistance of complications in pregnant women submitted to the labor in households. Non-compliance to comply with this resolution would be considered ethical infraction with discipline punishable.[12]

Understanding the Resolution 265/12 of CREMERJ as inconsistent with the Law 9,498 / 86 of 25 June 1986, which comprises the Professional Practice Nurses, the Regional Council of Nursing in the state of Rio de Janeiro (RJ-Coren) filed injunction in Public Civil Action, on July 27, 2012, at the 2nd Federal Court of Rio de Janeiro, who granted the injunction filed by Coren-RJ, suspending the effects of Resolutions No. 265/2012 of CREMERJ, which forbade the doctor in acting in home birth teams or integrating hospital boards of support and guard.[13]

The users of the Unified Health System, in the need for hospital care, are always referred to the public hospital health. In several European countries, the low risk birth is assisted by non-medical professionals - Obstetrician nurses and Midwives, limiting medical care only to high-risk deliveries. In these countries, home birth is inserted in the health system as a right of all pregnant women. The family while choose to deliver at home is inserted in the health system on alert, and in any emergency situation the mother is sent to the hospital. Women who need to buy materials for labor are subsequently reimbursed by health insurance.[14,15]

In the absence of logistical support the study showed that lack of political definition to effect systematically the practice of home birth in the country's health system, there is not logistical support institutionalized in private or public network that allows the purchase of medicines and materials for they are sometimes used in home delivery, once the purchase is restricted to the hospitals. In Brazil, 16 health services still stigmatize women who opt for a home birth. Managers, medical profession and even other nurses hinder the practice of integration in the health system in a formalized way.

For many years, the records of the newborn home birth represented the dilemma of birth underreporting, the deliveries by rural midwives who had no access to certificates of live birth - DNV - used for parents to do the civil registry children's birth. DNV was restricted to hospitals to refer to the Civil Registry Offices. The creation of the Ordinance n.116 / MS in February 2009 expanded the distribution of DNV, facilitating the document for midwives.[17]

Therefore, the distribution of DNV is the responsibility of the Department of Health Surveillance – SVS, and the following professionals may access the form: healthcare facilities, doctors, nurses and traditional birth attendants recognized and linked to health units, acting in home births were registered by the Municipal Health, Civil Registry.[17]

The role of nurses in the planned home birth is permeated by many barriers, however to overcome the challenges and obstacles many of them find solutions informally and temporarily, this certainly brings concern among the category.

Disclosure of childbirth care have provided increased professional credibility, many people appreciate, respect and support the work of nurses, but the disclosure appears to be a two-way street, because at the same time that the success of the work is well known, there is a system that seeks to raise criticism of the model, using the same media to belittle the practice.

It is noteworthy that in an attempt to discuss the conflicting situations experienced by midwives and other professionals attending the birth in July 2012 in Sorocaba, SP, the

National Midwife Urban Meeting occurred. The event brought final proposal as the creation of the "Letter of Sorocaba". This document highlights the role of women as a key element for delivery of the ransom as a cultural event. To stimulate the creation of new extra-hospital birth care spaces as well as protection of existing in the National Humanization of Childbirth Program of Health Ministry.

CONCLUSION

The best environment for childbirth is one in which the woman feels safe, it can be the home, a delivery center or maternity hospital. The residence is a safe environment for the birth, if it is a decision of woman and her family.

The homebirth planned throughout Brazil has been increased. There was an increase in the quantitative professionals who joined or directed assistance to planned home birth, and we can find this model of care across the country, with more expressive specialist nurses in the big cities and metropolitan areas.

Obstetrician nurses who attend home births seek to rescue the natural birth of low risk. To do this, they use scientific knowledge, the scientific evidence associated with cultural practices techniques used by traditional obstetrician nurses who contribute in relieving pain and helps in the process of labor evolution.

Although the Ministry of Health have already invested in job training and resolutions that support delivery care assisted by nurse, the current practice points to the need for greater progress with defined policies to ensure pregnant women the free choice of the place to give birth, seeking definitive solutions to address the still existing conflicts and or emotionally tense situations, which put professionals in pathfinders condition in normal birth care to low risk, planned at home.

This condition refers to the great challenges in the re-conquest of territory historically experienced by women as a natural right to give birth. This space sometimes is perceived as professionals acted against the technological advances implemented in services in health, but in fact what is called for in this model is a humanized care that meets the user in the birth process with quality and safety for mother and newborn.

The study revealed challenges, obstacles and lack of institutional structure to meet the specific need that support professionals in home birth. There is not a resolution to prohibit a woman from having her child at home, or to prevent the professional in performing this service. However, in Brazil, the public health system and the agreements do not cover financing of planned home birth, births are performed privately. Also, there is a lack of resolutions for the purchase of materials and medicines for both professionals articulate to overcome every challenge and find solution.

We must point out that there is sufficient information and evidence that support the quality of care for women in the birth process at home, as an alternative. We reiterate only one official regulation as a public health policy that provides proper insertion in the planned home birth for low-risk pregnant women, as a right of citizenship of the female population.

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Submission: 2015/08/04
Accepted: 2015/01/06
Publishing: 2016/02/01

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