



IMPLEMENTATION OF HUMANIZED CARE TO NATURAL CHILDBIRTH IMPLEMENTAÇÃO DA HUMANIZAÇÃO DA ASSISTÊNCIA AO PARTO NATURAL IMPLEMENTACIÓN DE LA HUMANIZACIÓN DE LA ASISTENCIA AL PARTO NATURAL

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ABSTRACT

Objective: to analyze the implementation of humanized practices in assisting the natural childbirth, based on the document "Good care practices for labor and birth", of 1996. **Method:** cross-sectional descriptive study conducted with 51 mothers in a rooming-in of a municipal hospital in Fortaleza (CE), Brazil, from September to October 2013, using a questionnaire. **Results:** 35.29% of women were between 20 and 25 years old, 64.71% have not completed high school and 76.47% reported monthly income of one salary. Effective practices of care during labor and birth stood out: empathic support by professionals (92.16%); use of non-pharmacological methods to relieve pain (90.20%); freedom of position during labor (74.51%); and inadequate practices: prophylactic venous catheterization (64.7%), pressure of the uterine fundus (62.7%) and transferring the woman to another room on the second stage of labor (82.3%). **Conclusion:** the proposed recommendations were performed. However, despite the existing limitations, there is urgent need of providing resources to pregnant women, respecting their freedom of choice. **Descriptors:** Humanized Birth; Obstetric; Normal Birth.

RESUMO

Objetivo: analisar a implementação das práticas humanizadas na assistência ao parto natural, fundamentada no documento "Boas práticas de atenção ao parto e ao nascimento" de 1996. **Método:** estudo transversal, descritivo, realizado com 51 puérperas, em alojamento conjunto de hospital municipal de Fortaleza (CE), Brasil, de setembro a outubro de 2013, por meio de questionário. **Resultados:** 35,29% das mulheres tinham entre 20 e 25 anos, 64,71% não concluíram o ensino médio e 76,47% relataram renda mensal de um salário. Destacaram-se práticas eficazes de atenção ao parto e ao nascimento: apoio empático pelos profissionais (92,16%); uso de métodos não farmacológicos no alívio da dor (90,20%); liberdade de posição durante o trabalho de parto (74,51%); e práticas inadequadas: cateterização venosa profilática (64,7%), pressão do fundo uterino (62,7%) e transferência da parturiente para outra sala no segundo estágio do trabalho de parto (82,3%). **Conclusão:** as recomendações preconizadas foram realizadas, no entanto, apesar das limitações existentes, urge oferta de recursos disponíveis a parturientes, respeitando a liberdade de escolha destas. **Descritores:** Parto Humanizado; Enfermagem Obstétrica; Parto Normal.

RESUMEN

Objetivo: analizar la implementación de las prácticas humanizadas en la asistencia al parto natural, fundamentada en el documento "Buenas prácticas de atención al parto y al nacimiento" de 1996. **Método:** estudio transversal, descriptivo, realizado con 51 puérperas, en alojamiento conjunto de un hospital municipal de Fortaleza (CE), Brasil, de septiembre a octubre de 2013, por medio de un cuestionario. **Resultados:** 35,29% de las mujeres tenían entre 20 y 25 años, 64,71% no concluyeron la enseñanza secundaria y 76,47% relataron renda mensual de un salario. Se destacaron prácticas eficaces de atención al parto y al nacimiento: apoyo empático por los profesionales (92,16%); uso de métodos no farmacológicos en el alivio del dolor (90,20%); libertad de posición durante el trabajo de parto (74,51%); y prácticas inadecuadas: cateterización venosa profiláctica (64,7%), presión del fondo uterino (62,7%) y transferencia de la parturiente para otra sala en la segunda etapa del trabajo de parto (82,3%). **Conclusión:** las recomendaciones preconizadas fueron realizadas, sin embargo, a pesar de las limitaciones existentes, urge oferta de recursos disponibles a parturientes, respetando la libertad de elección de estas. **Descriptores:** Parto Humanizado; Enfermería Obstétrica; Parto Normal.

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INTRODUCTION

The pregnancy is a singular moment in the life of women; it is an important milestone because it can be associated to the apex of her femininity, since the conception is a characteristic inherent to women. From the process that follows the discovery of pregnancy to the effective labor and finally the birth, the woman experiences a mix of feelings such as joy, fear and pain, and needs attention and emotional support.

Fear and pain are feelings that permeate labor, especially in the case of first pregnancy, since they are experiencing something new. In this way, the way the woman is cared for directly influences how she experiences this moment. The emotional state interferes in the evolution of childbirth and postpartum, resulting in interventionist practices that, in most cases, could be avoided with the support of the multidisciplinary team.¹

With the institutionalization of birth, going from home to hospital, there was the consequent medicalization through the interventional medical model, which started to determine the periods of parturition, taking away from the woman the starring role, i.e., as capable of conducting her own parturition.² These practices made the care during childbirth dehumanized, because the woman began to no longer decide on their health and actions related to their own body.³

Maternal and neonatal mortalities are important indicators of quality of care. Brazil occupies the 29th place in absolute numbers of maternal death. It was recorded, in 2007, 77 deaths for every 1,000 births. In addition to being a world leader in cesarean sections, reflecting its overly interventionist assistance model.⁴

Given the high rates of maternal and neonatal mortality, the World Health Organization (WHO), in 1996, released a document called "Good Care Practices for Labor and Birth," which lists a number of practices that are demonstrably useful and should be stimulated during labor and birth.²

In 2000, to promote humanized care in pregnancy and childbirth, the Ministry of Health established the Program for Humanization of Prenatal and Birth (PHPN) to ensure improved access, coverage and quality of prenatal care and care during delivery and postpartum for pregnant women and the newborn.⁵

In order to consolidate for women the right to reproductive planning and humanized care

in pregnancy, childbirth and postpartum, as well as to ensure for the child the right to safe birth and healthy growth and development, the Ministry of Health established also the *Rede Cegonha* (Stork Network).⁶

From this perspective, studies that reveal this everyday reality enable to review the view and the way of work currently adopted by the multidisciplinary team, hoping thus to improve the quality of care provided to pregnant women.

In this sense, this study aims to analyze the implementation of humanized practices in assisting the natural childbirth, based on the document "Good care practices for labor and birth", of 1996.⁷

METHOD

This is a descriptive, transversal study, with quantitative approach, performed in a secondary, municipal public hospital in Fortaleza-CE, belonging to the *Rede Cegonha*.

The sample found 51 mothers in a rooming-in, who had natural delivery, and aged over 18 years. Those admitted in the expulsive period were excluded, which impeded conducting humanized care practices for childbirth. The sampling took place by convenience.

Data were collected between September and October 2013, through questionnaire based in the Care Guide to Natural Birth of WHO and applied by the researchers. For processing and analyzing the results, we used the database in Microsoft Excel 2010 program.

The principles of research ethics were respected, in accordance with the Helsinki Declaration of 2000 and Resolution 466/12, and approved by the Ethics Committee, under number 18665813.3.0000.5052.

RESULTS

Analyzing how the implementation of these practices occurs leads to the need to know the socioeconomic, clinical and obstetric characteristics of pregnant women involved.

The highest number of deliveries was in young adult pregnant women between 20 and 25 years old (35.2%), with mean age of 24.1 and standard deviation of 5.9. With regard to marital status, most had a companion, whether in stable relationships (45.1%), or married (17.6%). They did not declare being illiterate, 35.2% reported having completed high school. It is inferred that the low level of schooling observed has direct impact on the employment situation and the type of profession, because 68.6% of the mothers were unemployed and 75% of them had not

completed high school. The 31.3% who were inserted in the labor market developed activities that did not require high average level of education (seamstress and domestic).

As for the obstetric situation, 82.3% of mothers did not have abortions. 72.5% underwent routine episiotomy, proving the hegemony of the medical intervention model,

because when asked about the reason for performing the procedure, the participants reported that the professional said that it would facilitate the birth. 11% of mothers had complications during labor and delivery. The problems mentioned by the participants were respiratory distress of the newborn and preterm delivery.

Table 1. Frequency of performance of demonstrably useful practices and that should be stimulated (Category A). Fortaleza, CE, Brazil, 2013.

Practices	n (%)
Empathic support by caregivers during labor and delivery	47 (92.1)
Providing women of all information and explanation as they desire	45 (88.2)
Freedom in positioning and movement throughout labor	38 (74.5)
Initiation of breastfeeding within the first postpartum hour	32 (62.7)
Ambulation	27 (52.9)
Respect for the right to companion during labor and delivery	26 (50.9)
Use of only the birthing chair	17 (33.3)
Massage	15 (29.4)
Aspersión bath	13 (25.4)
Use of the Swiss ball and the birthing chair	6 (11.7)

The practices carried out more often involve interpersonal relationship between the mother and team members, demonstrating awareness by some professionals.

The practices massage, use of the birthing chair and / or ball and aspersión bath were

performed less frequently. These require, in addition to awareness and professional availability, availability of physical resources and adequate infrastructure in the institution.

Table 2. Frequency of performance of clearly harmful or ineffective practices and that should be avoided (Category B). Fortaleza, CE, Brazil, 2013.

Practices	n (%)
Use of prophylactic venous catheterization	33 (64.7)
Use of the supine position during labor	24 (47.0)
Use of enema	1 (1.9)
Use of trichotomy	1 (1.9)

It was identified the completion of harmful or ineffective practices, such as prophylactic venous catheterization. This was associated in

100% of cases with fasting due to the possibility of anesthesia and surgical procedure.

Table 3. Frequency of performance of practices regarding those for which there is insufficient evidence to support a clear recommendation and should be used with caution until further research clarifying the issue (Category C). Fortaleza, CE, Brazil, 2013.

Practices	n (%)
Pressure on the uterine fundus during labor and delivery	32 (62.7)
Routine use of oxytocin	21 (41.1)
Routine early amniotomy in the 1st stage of labor	15 (29.4)
Nipple stimulation to increase uterine contractions during the third stage of labor	2 (3.9)

Evidence-based research allows conducting empirical studies and presents scientific evidence that guide care actions. However,

Table 3 presents practices about which there is no scientific proof and urging further studies to their elucidation.

Table 4. Frequency of performance of practices commonly used improperly (Category D). Fortaleza, CE, Brazil, 2013.

Practices	n (%)
Water and food restriction during labor	47 (92.1)
Routine transferring the woman to a different room at the start of the second stage of labor	42 (82.3)
Liberal or routine use of episiotomy	24 (47.0)
Stimulus to push before the woman feels the involuntary urge to push	18 (35.2)
Bladder catheterization	4 (7.8)
Repeated and frequent vaginal examinations for more than one professional	3 (5.8)

Water and food restriction, present in 92.1% of women, was related to the possibility of surgical procedure.

DISCUSSION

Young adult pregnant women are in an age group favorable to pregnancy, being less likely to have maternal and perinatal complications associated with teenagers or aging characteristics.⁸

Regarding the first recommendation, related to the offer of liquids during labor and delivery, it is observed that this routine is still motivated by fear of the possibility of aspiration of gastric content, if the patient is subjected to anesthesia for a caesarean section. However, this practice is not justified in all cases, since the labor and delivery require significant amounts of energy, which can further increase the discomfort and reduce blood glucose levels, resulting thus in risks to the fetus.⁸

As for the right to a companion, 50.9% of participants had, partially, that permission. The law was not enforced in its entirety, as restrictions on sex and stay in the delivery room were imposed by the institutional and professional culture.

Health services of the Unified Health System (SUS), its own network or a partner network, are obliged to permit the presence, next to the woman in labor, of a companion throughout labor and birth, delivery and immediate postpartum period.⁹

The presence of a companion contributes to improved health indicators, as it promotes several benefits scientifically proven, as the reduction in labor duration and oxytocin administration in the induction of it, and contributes to decrease the cesarean rate, the use of forceps and the need of analgesia.⁴

It was evident, also, the ignorance of mothers about the right to have a companion during this whole process, because when questioned, they reported not knowing this guarantee conferred by the Constitution. Thus, it is important that, during the prenatal care, pregnant women think about the choice of who could accompany her in the maternity ward so that the companion can be instructed as to their role in order to interact with the team in the humanized care to be provided during the experience of a moment so natural, as the birth.

Another recommendation is to encourage the mother, according to their motor dexterity, to change positions, such as sitting on the bed, on the chair, on the stool, side-lying, kneeling, squatting, hands and knees or

standing with trunk inclination. Postural changes can reduce maternal pain, facilitate maternal-fetal circulation and the passage of the fetus through the maternal pelvis.¹⁰

Although a large proportion of pregnant women had had freedom of movement and position during labor, 25.4% of them remained on bed rest because wanted to remain in this position or because they were not counseled on the benefits of movement and the adoption of upright postures to progression of labor.

The fact that most women refer satisfaction with the care received reflects that they do not hold knowledge about the humanization of care recommended by WHO, since inadequate practices that should be used with caution were conducted.

The empathic and effective communication conveys support, comfort and confidence, making the woman feels safe and respected as a person, and contributes to a more active participation of women in childbirth.¹¹⁻¹²

Regarding the use of non-invasive and non-pharmacological methods to relieve pain and discomfort, the Swiss ball is one of the best practices. Its use enables the active participation of women in the birth process because it facilitates the adoption of upright postures that reduce maternal pain, facilitate maternal-fetal circulation and the passage of the fetus through the maternal pelvis, alleviating uterine contractions and reducing perineal trauma.¹³⁻¹⁴

Maintaining this practice requires adequate number of balls, in addition to enough staff, since the use of the ball by the woman requires guidance and supervision of a health professional, as in the opposite situation can cause falls and should not be recommended.

The birthing chair was used more frequently in the study. Those that did not use it justified that they preferred not making use of this method and others reported that this resource was not offered. It is assumed that because the method does not require supervision of professionals, only guidance, it was offered more often than the Swiss ball. This method consists of a seat with armrests, which favors a sitting position with the back tilted forward and promotes pelvic swing.¹⁵

Massage is a sensory stimulation method that has the potential to promote relief of pain and relaxation effect, decreasing emotional stress, improving blood flow and oxygenation of tissues.¹⁰ According to the report of the mothers, this care was not offered in 70.5% of cases. It is emphasized that this practice requires professionals' time and readiness.

This situation could be ameliorated if the Companion Law was regularly fulfilled, since, in addition to the proven benefits to the mother, resulting from their presence, the companion, when properly oriented, can contribute to the nursing staff in performing simple types of care, as a massage.

Another possibility is the inclusion of Doulas. In cases where the mother does not have a companion, the Doulas can indeed help them to relax, breathe properly and calm them down.

A project developed in a Brazilian maternity entitled Doulas project - "Helping to born" describes this professional in the birth process as of great value in helping the team. The Doula acts giving emotional support, support in information to women and in physical comfort measures.¹⁶

A study found that women who ambulate have shorter duration of labor due to better uterine contractility, the decreased need for use of oxytocin and analgesia, and it reduces the need to carry out vaginal delivery with forceps and episiotomies.¹⁷ However, the freedom to stop walking when they want must be guaranteed to all pregnant women.

Music therapy and immersion bath were not used to alleviate the pain of any postpartum women. Among the non-pharmacological measures for pain relief, there is no need to carry out all, however, it is necessary to offer all available methods, respecting the freedom of choice of the puerperal woman.

Prophylactic venous catheterization was performed for the use of oxytocics and intravenous hydration. As recommended by WHO, 54.9% of pregnant women were encouraged to adopt upright postures and to walk, and did not remain in supine position throughout labor. However, some of the mothers who remained in the supine position reported not having received guidance; the minority of them remained on bed rest because they wanted to. The mothers gave birth in supine or lithotomic position.

It was found that, among clearly ineffective or harmful practices that should be avoided, the use of prophylactic venous catheterization, followed by the use of the supine position during labor, were the most frequently performed in that institution.

Even though exerting pressure on the uterine fundus, or the Kristeller's maneuver, is a proscribed procedure, it has often been performed in this study. This maneuver is known to be harmful to health and is configured as violence to the mother and the baby. It also harms the pelvic floor, the

perineum, causes uterine inversion, uterine rupture, as well as a series of complications in childbirth and postpartum and can even cause maternal or fetal death.¹⁸

Frequent overcrowding in hospitals or early admission can influence the realization of Kristeller's maneuver and administration of oxytocin to increase the turnover of the pre-birthing beds and the capacity to attend more patients.

None of the patients used systemic or epidural analgesia. Pain relief provided by pharmacological agents are indisputable, however this benefit may harm the maternal and fetal well-being. Its use is associated with some adverse outcomes, such as increased vaginal birth operative risk due to the relaxation, promoted by analgesia, of the pelvic floor, reducing uterine activity and suppression of the pull reflection during the second stage of labor.¹⁹

Thus, all non-pharmacological methods available to alleviate the pain of the mother must be used before opting for a pharmacological method that produces many negative effects and prevents the woman to take the starring role in the birth itself.

It is disapproved, however, the realization of repeated and frequent vaginal examinations, especially those made for more than one professional. The institution complied with this recommendation, as 94.1% of women reported holding up to six vaginal examinations throughout the labor, by a maximum of two professionals.⁷

The episiotomy was performed in 47.0% of cases, however this surgery should not be used deliberately and should be performed only in specific cases where there is fetal distress, failure of labor or when there is risk of serious and spontaneous perianal lesions.⁶

Because it is a surgical procedure, it must be informed and allowed by the woman prior to its conduction, otherwise it is configured as an obstetric violence.²⁰

Current evidence stand out pain, swelling, infection, dyspauenia, third and fourth degree lacerations and the negative effect of female body image as risks associated with this intervention.²¹

Among the practices used improperly, the three that stood out were water and food restriction during labor, followed by routine transferring the woman to a different room at the start of the second stage of labor and, finally, liberal or routine use of episiotomy.

CONCLUSION

There are many difficulties in providing humanized care to women during birth process. These difficulties relate to the need for trained and sensitized professionals to do so; to the availability of technological resources and adequate infrastructure of the institution; and it is also a time when the woman is susceptible to feelings such as joy, fear and pain, needing attention and emotional support.

We noticed that many of WHO recommendations for this moment were performed in the institution, however, despite the existing limitations, the care could be enhanced by the completion of humanized practices with all the patients. Simple measures, such as walking, breathing, showering, empathic support and the provision of information have no cost and depend largely on the sensitivity of the professional.

It is therefore urgent to sensitize the multidisciplinary team for humanized care, preparing them to perform a service based on respect, promotion of human, sexual and reproductive rights so that we can implement practices based on scientific evidence with the physical facilities and appropriate technological resources available.

Clearly harmful or ineffective practices and that must be avoided keep being employed: the use of prophylactic venous catheterization and supine position during labor were the most performed in the institution. Among the practices that do not have sufficient scientific evidence to support a clear recommendation and that should be used with caution, the most frequent were: the pressure in the uterine fundus during childbirth and the routine use of oxytocin.

Among the practices used improperly, there were water and food restriction during labor, routine transferring the woman to a different room at the start of the second stage of labor and episiotomy.

Demonstrably useful practices and to be stimulated were not offered to all pregnant women, as evidenced by the data: empathic support by professionals; freedom of position and movement throughout labor; and use of non-invasive, non-pharmacological methods of pain relief. Among the non-pharmacological measures for pain relief during labor, there were: breathing technique, ambulating and the birthing chair.

Nurses, especially the specialist in obstetrics, take an extremely important place

in care, being able to target and sensitize the multidisciplinary team for humanized care as a way to change the current scenario of obstetrics.

Professional associations must walk along with professionals, seeking to establish a process of integration with society, government officials, Nursing Schools and Universities, bringing together multidisciplinary and multisectoral efforts with the social commitment to improve women's and the newborn health conditions, in the defense of citizens' rights guaranteed by the Constitution.

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