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

ORIGINAL ARTICLE

WOMAN'S AUTONOMY IN THE CHILDBIRTH PROCESS

AUTONOMIA DA MULHER NO PROCESSO PARTURITIVO

AUTONOMÍA DE LA MUJER EN EL PROCESO DE PARTO

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ABSTRACT

Objective: to analyze prenatal care, labor and delivery, from the perspective of women attended by the National Health System. ***Method:*** descriptive study of qualitative approach. The sample consisted of 21 participants pregnant women who received prenatal care at Basic Health Units, and mothers who gave birth in public hospitals or accredited private institutions of the Health System. For data collection was used semi-structured interview. After transcription in full, the speeches were separated by similarity and structured into categories, and then were analyzed and discussed in the literature. ***Results:*** two thematic categories emerged after the analysis of the interviews: << Prenatal care >> and << The labor and birth >>. ***Conclusion:*** the data showed situations such as difficult access to prenatal care, misinformation about the conduct and procedures to be followed, lack of women's participation in decision making and the absence of companions during childbirth. ***Descriptors*:** Prenatal Care; Humanizing Delivery; Unified Health System.

RESUMO

Objetivo: analisar a assistência ao pré-natal, parto e nascimento, sob a ótica de mulheres atendidas no Sistema Único de Saúde. ***Método:*** estudo descritivo e exploratório, de abordagem qualitativa. A amostra constituiu-se de 21 participantes gestantes que fizeram o pré-natal em Unidades Básicas de Saúde, e puérperas que pariram em maternidades públicas ou instituições privadas conveniadas ao Sistema Único de Saúde. Para a coleta de dados, utilizou-se entrevista semiestruturada. Após a transcrição na íntegra, os discursos foram separados por semelhança e estruturados em categorias e, em seguida, foram analisados e discutidos com a literatura. ***Resultados:*** duas categorias temáticas emergiram após a análise das entrevistas: <<Assistência pré-natal>> e <<O parto e nascimento>>. ***Conclusão:*** os dados evidenciaram situações como dificuldade de acesso ao pré-natal, desinformação sobre as condutas e procedimentos a serem adotados, ausência da participação da mulher na tomada de decisão e ausência do acompanhante no parto. ***Descritores*:** Cuidado Pré-Natal; Parto Humanizado; Sistema Único de Saúde.

RESUMEN

Objetivo: analizar la atención prenatal, parto y nacimiento, desde la perspectiva de las mujeres atendidas en el sistema único de salud. ***Método:*** estudio descriptivo y exploratorio, enfoque cualitativo. La muestra consistió de 21 participantes que hicieron control prenatal en Unidades Básicas de Salud, madres embarazadas y recientes que dieron la luz en maternidades, instituciones públicas o privadas bajo acuerdos con el sistema unificado de salud. Para la recolección de datos, se utilizó la entrevista semiestructurada. Después de la transcripción en su totalidad, tuve los discursos separados por similitud y estructurados en categorías y, que después, fueron analizados y discutidos en la literatura. ***Resultados:*** dos categorías temáticas surgieron tras el análisis de las entrevistas: << atención prenatal >> y << parto y el nacimiento>>. ***Conclusión:*** los datos mostraron situaciones como el difícil acceso a atención prenatal, información errónea acerca de las conductas y procedimientos que deben ser adoptados, la ausencia de la participación de las mujeres en la toma de decisiones y la ausencia de acompañador en el parto. ***Descriptores*:** Atención Prenatal; Parto Humanizado; Sistema Único de Salud.

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INTRODUCTION

Since 1996, there have been significant changes within the parturition process, the World Health Organization (WHO) has prepared a document "Good Practices in Attention to Labor and Birth" as a routine procedure in obstetrical practice. In this perspective, the humanization of labor and birth is aimed at reducing maternal and peri-neonatal mortality from overcoming the technocratic model by the humanist values which the physiological process of childbirth and the mother as the protagonist in childbirth.[1]

Since 2000, the Ministry of Health established the Program for Humanization of Prenatal and Birth - PHPN. The humanization of obstetric care is in direction to sediment actions, especially in Basic Health Units and hospitals with the Unified Health System - UHS. The development of assistance activities in establishing ethical principles based on relationships, privacy guaranteeing autonomy and guidance to women in the birth process. Assistance to prenatal care and childbirth should ensure pregnant women the benefits of scientific advances.[2]

The values that guide the humanization, establish secure access to all women seeking services, early identification of pregnant women to health services, information for the mother in advance of the birth site, right of users to have a companion during service, participating in conduct of decisions to be adopted. The emphasis on dialogue and negotiation of routine procedures is important in improving the professional relationship and the user.[3-5]

It is noteworthy that, in this care, approaching states and municipalities must have the network services organized with established mechanisms for referral and counter-referral from the link between Basic Health Units and maternity wards, ensure human resources and infrastructure, conduct additional tests to ensure vacancy for the pregnant woman's transfer and/or neonatal in proper transport, the right to escort in prenatal visits, labor and delivery and the postpartum stage; encouraging normal delivery and reducing unnecessary caesarean section. In this perspective, in 2011, the Ministry of Health launched the "Stork Network". [6]

Although the Ministry of Health has expanded care coverage to prenatal care and childbirth, educational activities for the pregnant woman to the rights, autonomy and empowerment of the mother for natural childbirth is still constitute as a problematic in obstetric practice in the health service. In this understanding, this study aims to: analyze the prenatal care, labor and delivery, from the perspective of women attending the National Health System.

METHOD

A descriptive study of qualitative approach, developed with users of Goiânia Health System, Goiás. The sample consisted of 21 participants, pregnant women who received prenatal care at Basic Health Units, and mothers who gave birth in public hospitals or private institutions in the Unified Health System. The amount of participants was determined by data saturation.

Inclusion criteria: normal risk pregnant women with gestational age of 35 weeks and postpartum women up to 30 days postpartum. Pregnant women who do not attend the unit on the date scheduled for interview and return visits; mothers previously counted, but were not at home when the postpartum visit were excluded.

Data collection was conducted from May to July 2013 through semi-structured interviews using a voice recorder. The interviews were conducted by the researchers, and after the full transcript, the speeches were separated by similarity and structured into categories, and then were analyzed and discussed in the literature. In order to maintain the integrity of all respondents, they were given pseudonyms.

This study was approved by the Ethics and Research of the Clinical Hospital of the Federal University of Goiás Committee, CAAE 35107814.4.0000.5078, and serves Resolution No. 466/12 of the National Health Council.

RESULTS

The characterization of the profile of the interviews were identified: women are the majority aged between 20 to 25 years (62%); marital status: stable (44%); Elementary school education (57%); family income: a minimum wage; profession/occupation: housewife (47%). The 21 pregnant women received prenatal care in Basic Health Units, 14 mothers reported that delivered in public hospitals in seven partner institutions to the UHS.

The analysis of the reports came from the experiences of pregnant and postpartum women users about the quality of care in the Unified Health System in discourse analysis was drawn up two thematic categories: "prenatal care" and "childbirth".

Pre-natal

The tests were described by pregnant women as easily accessible. Reported it being easy to perform and associate this facility to the fact that blood collection being the first prenatal consultation by the nurse in the health unit.

> *I had difficulties in carrying out the tests. I did everything, Mom's test at the first visit and the seventh month. I found it very good, did it there in the unit (E-4).*

Already, in regards to consultations on the Basic Family Health Unit (BFHS) women that were cared for, reported satisfaction in service because their return was already scheduled and the marking was made on site quickly, according to the lines:

> *Wow! prenatal care was good, had no complaints, I marked the consultations there and the next visit was already scheduled (E-10).*
>
> *In the FHP you go to the first visit, at the time that you leave you already hand in the pregnant woman's card and they mark your return faster, through 0800 it takes a long time (E-13).*

Also reported satisfaction with the nursing consultation. Mentioned are physical examinations, anthropometric measurements, blood pressure measurements, measurement of uterine height and auscultation of fetal heart beats. These procedures are recommended in obstetric care and were considered as a criterion of good service by users.

> *What I liked most was when her blood pressure, measured the belly, placed a gadget to listen to the little heart of the baby [...] (E-4)*

It was found that the majority of subsequent queries were performed with more than one physician. In the first visit by a nurse, however, pregnant women built the nurse's image as a nursing technician:

> *She measured the pressure and weighed me, she did that Mom test, filled in the card, did not directed to anything! (E-2).*
>
> *It is the nurses who meet us, those nurses who are just sticking the people's veins. I never talked to the doctor, she stays there substituting the doctor (E-12).*

Pregnant women who perform prenatal care described difficulties to schedule the "0800" tele schedule because it transfers the responsibility to the woman of getting to guarantee their seat for monthly consultation. The tele schedule was created to facilitate access actually has been an impediment to access to prenatal care:

> *There at the station they say that no agenda not. I was more than a month without consulting. I called several times in 0800 and nothing [...] (E-9).*
>
> *I tried a lot! in 0800 I was not getting. It was all very up because I was not getting job in late pregnancy. This I found a mess out of control, very uncontrolled (E-10).*

A lack of information was revealed about the birthing place and procedures. In prenatal women report feelings of distress about the situation:

> *They did not guide me, it was just at the time. Prenatally nobody said anything, it is bad not know (E-4).*
>
> *They said that's the last time you have to call mobile transport and they refer to any place, they do not tell you where you will be (E18).*

The statement revealed that it lacked giving information about the location of birth. The pregnant women were sent only at admission. It was also found that during the prenatal care there was no guidance on the normal labor and measures to be adopted in the parturition process. Some mothers report disinterest and rudeness of professionals to explain the procedures:

> *He made the appointment for the cesarean and that was it, but he gave no further explanation. The doctor did not answer a lot of questions and did not give confidence (E-9).*
>
> *They should clarify the types of deliveries for people not demonstrating so much fear, they should explain 100%, no one ever told me how the normal delivery procedure was and the cesarean delivery (E-18).*

Usually, it is up to the nurse as coordinator of educational activities to strategize and make dynamics that promote dialogue with the woman and her companion, clarify their doubts and fears about the gestational process, childbirth and postpartum stage. The discussion contributes to the prevention of anxiety and contributes to women's empowerment becoming an active agent in the birth process.

♦ Labour and Birth

The hospital stay for childbirth has been described with feelings of anxiety and fear. The interviewees describe desire for a fast delivery, dissatisfaction with the physical space and the excessive use of invasive procedures, such as the touch test. In childbirth the doctor imposed on the decision of choosing the type of delivery. Most had a preference for vaginal delivery, cesarean section is the prevalent in most performed deliveries. Doctors and nurses do not value the presence of the companion and asked no opinion of pregnant women in measures to be adopted:

The doctor examined me and he did to the nurse with his hand (to send me to another place), he gestured for her, I just saw it, he did not tell me (E-7).

Doctors were whispering to each other as if I was not there. My husband was in the room with me, but they did not speak to him (E-21).

Doctors were uneducated and also nurses (E-8).

Most pregnant women also said they were not questioned about the choice of the type of delivery. Some of them feel the need to have the right to choose and be assisted in their wants and desires. One of them even states that the fact that they shed light on the types of labor leads to decrease fear.

Being a normal or not normal delivery, should clarify this more not to pass so much fear, I think it could give a little more chance to choose, I think I could choose (E-18).

I thought it was bad because I think they should do what we think. He did not answer my delivery option and neither wanted to know what I wanted (E-21).

The preference of women for normal delivery because they consider the recovery faster, healthier and natural, have lower risk than cesarean section:

I wanted a normal delivery, say that the recovery is faster and does not have much risk. The name says normal birth is natural, it is healthier (E-4).

Of course everyone knows that the normal delivery is more natural, it is better (E13).

In relation to the delivery option, according to the testimony of the mothers of the medical indications to perform caesarean section were amniorrex "dry delivery," macrosomia, no dilation and previous cesarean section:

The doctor has put the papers that would be a C-section, because I was not able to have normal delivery, he said that my delivery was dry (E-10).

The doctor said that due to the size and weight of the baby it could not be normal, it was 3,570 and 50 cm (E-21).

I had no condition of normal delivery because the two previous ones were cesarean. The doctor said since you had a cesarean section, I will not try normal (E-20).

The doctor said it would be caesarean because I was not dilating, I was hospitalized ten in the morning, it was one o'clock at the time he said he would do cesarean section (E-1).

The weight of medical opinion for women is very strong. Speeches reveal:

I was not dilating, so the doctor decided to do a cesarean section. Then I said if the doctor said, he could do it(E-7).

I did not feel anything for my baby to be born, she was already in place, to induce my labor should be worse, there the doctor preferred to do a cesarean section, so it was better, right (E-18).

In the maternity care for interning for child labor was described as a moment of difficulty as expected, go several times to the maternity to be hospitalized. Factors that caused anxiety and fear were highlighted:

It was hard, I was, feeling sick, until I had the baby I had to come over 1000 times we get too anxious waiting (E-2).

Several times I went to the maternity feeling sick, came home, they said that it was not time and I looked [...] very difficult, nothing happened, and I feel the pain! (E10).

I think the service took about 5 minutes they touched me and sent me home, no more medicine for pain relief (E-11).

Also reported concern of not getting a spot, being sent home in pain and do not knowing which maternity ward they would be going into labout. In relation to the fear of not getting to the maternity ward, some women described the difficulty of transport:

I got to have my baby here and had no vacancy, so I got scared and worried they would send me away home (E-3).

He had no job, I had to look for another hospital, there was no ambulance, there was a woman with nine months who went to another maternity by bus (E-16).

I was too scared to get there in time and freak out, you'll be given an account to call someone to pick me up, I'll be I'll get there in the maternity ward, will be whether they will see me (E-18).

Most women want a quick delivery. At the time of delivery most consider good care that which does not take a long time:

I was well attended. They applied a serum, which came faster pain, then applied the serum and it was not long, that's good (E-8).

Also, they mentioned dissatisfaction with the physical space at admission:

The expected delivery was bad, put me standing up feeling pain, they had to have at least one place for me to sit, then the girl who was with me said lay on my lap, so I lay in that cold, hard seat, I looked at the face of a nurse and she was talking as if there was no one there. I was upset, they could have a got better little place (E-8).

In the reception did not allow the companion a entrance at admission. Some mothers reported that the companions had the desire to attend the birth of their children, described the frustration of family

members not having guaranteed the right to share such a special moment, even though that presence is a right of the companion, according to the Law n.11.108 / 2005:

> *At the time I thought my husband was going to be me, but could not. No one could stay there in the hospital. He took me to the door left the trains (clothes) and came back and I was [...] alone (E-3).*
>
> *They said they could not get anyone to me, my sister wanted to go, she was glad he was going to see his nephew was born, then became sad. It's so bad to stay there sick alone, he had me would be better (E-8).*

The professional support during labor and delivery, it was described favorably. The interviewees described feeling calm, secure and well-served to be accompanied by someone, as noted in the reports:

> *The nurse helped me when the contractions came, did a massage on my back, she walked with me, stayed with me until the time of birth, I felt much better and safe with it (E-4).*
>
> *Every time a lady was there and kept asking how I was, taught me breathing, super well attended (E-7).*

Most respondents said that the labor incentive behaviors are adopted in ambulation in order to stimulate and accelerate labor. In a maternity in relation to freedom of position at delivery, the mother had the support and respect of their wishes. This approach features a humanized assistance to childbirth and birth, as observed in the speech of the mother:

> *I was walking around the yard, the doctor said to walk and move stop the baby down faster. When he was about to come out the doctor helped me and stood by me, I crouched sideways on the bed and back (E-11).*
>
> *I sat in bed, I thought it was too low and said I wanted to go up a little higher for the doctor to go up, I made the way it was good for me and the doctor accepted (E-17).*

One of the interviewees describes her negative experience of previous birth when the doctor did not allow the position change in pain (uterine contractions):

> *In the previous delivery at birth I wanted to change position and the doctor did not accept, for me it was horrible like that, it hurt my back, he wanted me to stay with the hip here on the bed and straight down , aching I wanted to go up a bit I felt more comfortable, he did not accept, I went up and I he would send me down (E-17).*

In this study, it was found that most of the women interviewed said that the adopted position was mostly horizontal and in relation to actions that affront a humanized assistance to childbirth and birth, two reports reveal sense of submission to staff:

> *I almost did almost all the positions. There on the wall there is a regulation at the time you enter the room, the mother does not need to submit to what they say. I do not think he needed to put me in that position. People are ashamed of squatting like Indian, squatting on the wall he put me there by force and I said that my legs were aching with pain. Yeah, he saw that I couldn't do it and kept putting me in these positions, he put me on my side with my leg on it to go forcing (E-21).*

With regard to food and water at the time of labor and delivery, women report satisfaction with this practice.

> *I ate cake and juice in the evening and over night they gave me soup before having the baby, left a jug of water, it was good (E-11).*
>
> *I drank water all the time during labor my husband took the bottle filled it and I drank, I spoke to the doctor to wait a little for me to drink water, then he: okay be calm at the time your pain comes you can force the deal is with you not me, my service is just at the time you are born, it was good I liked it (E-18).*

Concerning the right of analgesia during childbirth women describe satisfaction for not feeling pain:

> *I was no longer putting up with pain, they gave me anesthesia in my spine and put in an IV. When they told me I had anesthesia I said, I do not believe I will not feel pain (E-11).*
>
> *One lady said she had anesthesia, I thought, that's good I will not feel pain (E-12).*

Postpartum, rooming is encouraged to strengthen the mother-child interaction and breastfeeding. The women during hospitalization reported the absence of nursing staff to support the pain postoperatively.

> *I was very sore and after the effort I made to get up and down from the bed, the nurses did not help me (E-8).*
>
> *I called the nurse and said I could not manage to bathe the baby, there was no bench, I was in pain (E-21).*

Breastfeeding in the first hour of birth is not a universal conduct in all maternity hospitals, but after birth breastfeeding is encouraged by speech therapists, nurses, doctors and nutritionists, especially in public hospitals:

> *I have given the breast to him, I had no milk and the baby was crying from hunger, then they gave a milk cup to him, the nutritionist explained to me (E-12).*
>
> *The doctor taught me, telling me the right way to do it, for the baby to get it well, he*

> *saw if the milk was really leaving the breast, if it had not he would not discharge us, they give preference to child (E-17).*

However, in private hospitals, the mothers we oriented to the practice of breastfeeding, but there was no incentive to relationship and help and, there was impatience of professionals, as noted in the speech:

> *The nurse was very nervous, was teaching me to breastfeed and tucked the boy in my chest as if it were an object, without patience, like this is difficult (E9).*

In summary, this study found that the woman humanization policy in the pregnancy-puerperal period is not fully implemented in public or licensed services to UHS. There are still the biomedical paradigms and scientific-technical assistance to prenatal care, childbirth, breastfeeding and accommodation together. Some health professionals have proven to be guided in biological and interventionist aspects.

DISCUSSION

The study revealed that the humanistic paradigm in humanized prenatal care still have weaknesses in the Family Health Strategy. There is no predominance of educational practices in which they are listening to the exchange of knowledge and participation of the subjects valued. To change this scenario it is necessary to invest in vocational training, training as a way of building practices that incorporate the basic information focused on health promotion and not centered only on disease.[7]

Although being, the first prenatal visit, systematically, it is the nurse subsequently most are performed by a physician. The nurse performed when the professional image consultation was associated with technical nursing procedures.

In general, most women began prenatal care before sixteen weeks of pregnancy and made between eight to twelve queries. However, regular consultations process across a complicating access factor, tele 0800 schedule that interrupts the continuity and security of consultations.

The Ministry of Health recommends prenatal care to early identification with first consultation up to 120 days of gestation, the minimum of six visits, preferably one in the first quarter, two in the second and three in the third trimester of pregnancy. The interval between four weeks and consultations after the 36th week of monitoring pregnant women every two weeks, to evaluate and prevent possible complications.[8]

With regard to the evaluation of nursing consultation in a prenatal care study found that despite the difficulties encountered, the nurse's residence is essential to implement educational activities in health, inherent to the professional. There is need for efforts to ensure that the nursing consultation is no longer just a place to conduct a vaccine for pregnant women or place to clarify some information that the doctor did not.[9-10]

From the perspective of empowerment and women's role in childbirth, the humanized assistance presupposes respect for differences, appreciation of the role and autonomy of the subjects and the centrality of dialogue permeating relationships.[14]

The physical and psychological abuse represents a complete and radical denial of the rights of users and that violence is trivialized in everyday public hospitals and is expressed in the "objectification" of women is not recognized as a subject in relation to the health care professional, but as the object of intervention. The study shows reprisal reports, rude and hostile treatment, devaluation of women's pain and disqualification of their complaints. The analysis revealed that the trivialization of institutional violence carries the trivialization of suffering and results in their own invisibility.[11-3]

Possibly the mother's invisibility is the result of a biologist and technical conception that takes the woman the role of subject and makes it an object that is liable to manipulation. Unlike other societies and periods, pregnancy is no longer seen largely as a "natural" process of the body to be one that requires intervention and medical control.[14-5]

The woman does not find the professional a person with availability to see her as a person and to treat her with attention, affection and express concern. Bad service is qualified by feelings involving suffering, loneliness and neglect. The patients realized that professionals assist them inattentively and decommitment.[14-5]

The labor and delivery event for women, indicates how much the experience of hospitalization still shows in their eyes as a threat to women's dignity. The representation of hospitalization as an experience of a place of abandonment in which they will be subjected to procedures and the professional domain, translating thus how the mother has been subjugated by the authority of knowledge, without having space to have a say about the care they receive and even on the decisions that are taken in relation to the therapeutic process to which they are submitted.[16]

CONCLUSION

The study found that most women attending the Family Health Strategy initiated prenatal care before sixteen weeks of pregnancy. This denotes the incorporation of warm pipes as recommended by the Ministry of Health. However, the Comprehensive Care Health Centers noted it was found that the process of regularity and continuity of prenatal care had disabilities, as there was difficulty in scheduling appointments. The determination to turn the tele schedule - 0800 became a complicating factor access and ensuring continuity and prenatal care regularly understood beyond a chronological continuity, but rather also the link between the mother and the health worker.

Most prenatal consultations were carried out by a doctor, but systematically, the first responsibility of the nurse and health education. However this service was not observed or remembered by the deponents. One possible explanation for this omission is due to the popular imagination that prenatal care is exclusive to the doctor, but also due to the little interest of some nurses to participate in this process, which could be rethought.

The humanization of delivery and birth includes information to users and family. This study showed that the actions of the professionals are far from ideal, as the women attending both public and private hospitals declare lack of dialogue, little appreciation of their will and lack of negotiation on procedures and conduct. The image of the mother is described as devoid of personality and autonomy, in that it is presented with little decision in choosing the type of delivery and other behaviors in their birth process.

The study found that mothers expressed loneliness in the rooming. The practice of rooming devoid of support from the nursing staff has become a frustrating experience for the mother. This does not mean that the practice of rooming is bad, but that without proper health professional support as well as the family this may prove meaningless for mothers.

The World Health Organization (WHO) has developed a practical classification for conducting normal delivery, guiding the procedure than whether or not to perform it. In the study the practices accepted as useful and beneficial to respect the mother's choice of place of birth, receive information and be empathic supporting the health team were occasionally encouraged. But others were slightly stimulated, such as the supply of fluids during labor and delivery, non-invasive and non-pharmacological pain relief, freedom of position and movement throughout labor, encouragement of non-supine positions and support the initiation of breastfeeding in the first hour after delivery.

This study revealed that women are not informed properly about the stages and duration of labor, which made the birth process be riddled with fear and anxiety.

In general, we realize that there are some elements that deserve to be highlighted. First, the design of the interviewees there is a lack of attention of health professionals; second, there is a view that to be well attended the service must be paid, so the idea that the particular service is better; third, the perception of the interviewees of UHS is understood almost just as work of professionals, disregarding it as a humanization of health policy which is well structured in its design, but in everyday practice managers and professionals end up being dismantled .

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Submission: 2016/04/28
Accepted: 2016/10/19
Publishing: 2016/12/01

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