



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ORIGINAL ARTICLE

DELIVERY AND BIRTH HUMANIZATION: EMBRACING THE PARTURIENT FROM PAULO FREIRE'S DIALOGIC PERSPECTIVE

HUMANIZAÇÃO DO PARTO E NASCIMENTO: ACOLHER A PARTURIENTE NA PERSPECTIVA DIALÓGICA DE PAULO FREIRE

HUMANIZACIÓN DEL PARTO Y NACIMIENTO: ACOGER LA PARTURIENTE EN LA PERSPECTIVA DIALÓGICA DE PAULO FREIRE

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ABSTRACT

Objective: to analyze the parturients' perceptions with regard to the meaning of humanized delivery from the Freirean perspective. **Method:** this is a qualitative study, with a research-action nature, with the participation of eight parturients in early labor assisted at a maternity hospital in the countryside of the state of Ceara, Brazil. For data collection, one used direct observation of participants and an interview based on Paulo Freire's dialogicity. The information was addressed through Content Analysis. The study was approved by the Research Ethics Committee of Universidade Federal do Ceara (UFC), under the CAEE n. 0013.0.039.000.10. **Results:** one identified feelings of fear, lack of confidence, and lack of knowledge on the delivery process expressed by the parturients and they converged on the need for inclusion of a companion at the labor time. Also stood out the lack of an environment with privacy. **Conclusion:** It's important and needed to implement a delivery humanization policy which enables the appreciation of care for the woman during the delivery process. **Descriptors:** Delivery Humanization; Pregnant Women; Nursing.

RESUMO

Objetivo: analisar as percepções das parturientes quanto ao significado do parto humanizado na perspectiva freiriana. **Método:** trata-se de estudo qualitativo, do tipo pesquisa-ação, no qual participaram oito parturientes em início de trabalho de parto atendidas em maternidade do interior do estado do Ceará. Na coleta de dados foi utilizada observação direta das participantes e entrevista com base na dialogicidade de Paulo Freire. As informações foram abordadas por meio da Análise de Conteúdo. O estudo foi aprovado pelo Comitê de Ética em Pesquisa da Universidade Federal do Ceará (UFC), sob o CAEE n. 0013.0.039.000.10. **Resultados:** foram identificados sentimentos de medo, insegurança e desconhecimento sobre o processo do parto expressos pelas parturientes e eles convergiram para a necessidade de inclusão de acompanhante no momento do parto. Também se destacou a falta de um ambiente com privacidade. **Conclusão:** é importante e necessária a implantação de política de humanização do parto que possibilite a valorização da atenção à mulher durante o processo de parto. **Descritores:** Humanização do Parto; Gestantes; Enfermagem.

RESUMEN

Objetivo: analizar las percepciones de las parturientes con relación al significado del parto humanizado en la perspectiva de Freire. **Método:** esto es un estudio cualitativo, del tipo investigación-acción, en lo cual participaron ocho parturientes en inicio de trabajo de parto atendidas en una maternidad en el interior del estado de Ceará, Brasil. En la recogida de datos fue utilizada observación directa de las participantes y entrevista con base en la dialogicidad de Paulo Freire. Las informaciones fueron abordadas por medio del Análisis de Contenido. El estudio fue aprobado por el Comité de Ética en Investigación de la Universidade Federal do Ceara (UFC), bajo el CAEE 0013.0.039.000.10. **Resultados:** fueron identificados sentimientos de miedo, inseguridad y desconocimiento acerca del proceso del parto expresados por las parturientes y ellos convergieron para la necesidad de inclusión de acompañante en el momento del parto. También se destacó la falta de un ambiente con privacidad. **Conclusión:** es importante y necesaria la implantación de política de humanización del parto que posibilite la valorización de la atención a la mujer durante el proceso del parto. **Descriptores:** Humanización del Parto; Mujeres Embarazadas; Enfermería.

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INTRODUCTION

Childbirth care, historically, was developed by traditional midwives (lay people), who mastered techniques, but they had no scientific knowledge. Over time and due to the need for qualifying this action, physicians and nurses took this responsibility, a fact which fostered certain technological innovation. These changes led to several changes in the care for parturients in the perinatal period. Maternal and child care is no longer a care activity conducted at any space of the community's territory and it started being developed within the space of a maternity hospital under a health care rationale, with a strong technological component.

From this perspective, when a woman has an indication for normal vaginal delivery and she's admitted to a maternity hospital routine procedures are used, such as: hair removal, venous access installation, enema or clister, bed rest, fasting, delivery at the lithotomy position, excessive perineal handling during the delivery period, Kristeller's maneuver, and prohibition of a companion's presence, among others. Guidelines aren't always offered to the woman and her relatives, and the environment experienced is the hospital, with bright lights, subjects going in and out and talking, and lack of privacy, something which generates a stress atmosphere for the mother, the baby, and their family.¹

Devaluation of natural childbirth and the increasingly frequent practice of unnecessary surgical interventions show how the female population is lacking information and health education. The health professional-client relationship, usually asymmetric, leads women, feeling less able to choose and enforce their wishes, to have difficulties for participating in decisions on the technical issues raised by the health professionals.²

Through changes in childbirth care, the Ministry of Health decided to institutionalize delivery humanization and defined it as a set of behaviors and procedures promoting healthy pregnancy, delivery, and birth, since it observes the natural process and avoids unnecessary or risky conduct for the mother and the baby, strengthening women's autonomy in a dignified and libertarian, with regard to the process involved in prenatal care, delivery, and puerperium, and it depends on them to choose where, how, and with whom giving birth.³

Humanization of assistance is of utmost importance to ensure that a special moment, such as childbirth, is experienced in a positive

and enriching way. Resuming human contact, listening, accepting, explaining, and creating a bond are indispensable factors in care. As important as physical care, performing proven beneficial procedures, reducing the interventionist measures, privacy, autonomy, and respect for the parturient, aspects advocated by the Prenatal, Delivery, and Childbirth Humanization Program (PHPN), established by the Ministry of Health, in 2000. Despite more than 10 years ago, this reality is far from approaching what has been theorized from what has been institutionalized.^{4,5}

Thus, the view of being human is very far from that postulated by counseling as an education activity from Paulo Freire's perspective, since the man he thought through is an existential being, he's in the world and with the world. It isn't possible to encourage this man to change without understanding his existence, his view and interpretation of this world. According to Freire, counseling should be conducted from the dialectic, reflective, and critical perspectives, and it may be effective as an instrument for forming a critical consciousness and, thus, it will allow understanding the human being's reality towards his autonomy.⁶

Regarding the study reality, the formation of a pregnant women's consciousness will allow understanding the evolution of humanized delivery, for their autonomy and safety. One views, then, the delivery humanization in a broad way, as an education activity, an intervention act towards the subject's autonomy. The education intervention, from this perspective, is an act of knowledge; it's communication, dialogue, and interaction. So, the human being is the subject of his education, he can't be its object, this way, according to this conception, no one educates anyone. Education is exchange, men and women mutually educating and being educated. It should be disinhibiting, liberating, a changing force, developing the impetus to create. Therefore, there's a need for providing students with freedom to decide and make their choices. That's why it's political, because it's a project under construction, imbued with hope and fight.⁷

Thinking through the idea of women's care humanization during labor, this will only be possible if there's an involvement between the professional and the parturient. Humanization starts through communication, the relationship between subjects, based on respect and expressed by acts of love, listening, caring, and observing.⁸

The research based on the Freirean assumptions enables dialogue as an education moment, since the subject brings along the reality experienced; through it, the researcher shares with this subject the construction of issues to be explored and discussed. Through this construction elaborated between researcher and subject, there'll be a deconstruction of what was addressed and what isn't coherent, so that a new reality is reconstructed later on.

The theme is relevant because it deals with situations involving an important time for women, the time of giving birth, at which, often, there isn't a sensitive and appropriate listening on the part of professionals in order to understand the context of this moment, frequently unique in the woman-mother's life. And the lack of knowledge with regard to the childbirth process makes women dependent on the actions of other people, something which turns it into a time of suffering and distress. From this, it's possible to identify the elements and contexts determining this set of problems, by allowing the unveiling of this phenomenon and the creation of strategies to improve care.

This way, the study aimed to analyze the parturients' perceptions with regard to the meaning of humanized delivery from the Freirean perspective.

METHOD

This is a study with a research-action nature, under a qualitative approach, conducted at a maternity hospital located in the countryside of the state of Ceara, Brazilian Northeast region, which is a reference institution for eight towns, within the period from January to July 2010. The health service indicated has 20 obstetric beds with a rooming-in care nature, distributed as follows: 6 for antepartum and 14 for postpartum.

This theoretical proposal allows the researcher to instrumentalize a methodology for embracing supported by Freire, according to the following sequence:

- The construction of experienced reality: at this moment, one identifies the parturient's significant reality. It's the construction time, when the researcher, through dialogue arousing the woman's curiosity, explores issues related to her everyday life, her worldview, her perception with regard to childbirth, her vulnerability, and her history. Through this dialogue, the researcher encourages the subject to

ask her question, allowing discussing, demystifying, and working out practical examples of existential situations experienced by the subject.

- The deconstruction of reality: this is the time of encoding and decoding the issues brought by the parturient, starting from the context experienced by her and the practical examples raised by the researcher/facilitator. As one dialogues with the subjects, it becomes evident for one or another the less clear point, discussing it. The questions which may be asked at this moment are: Why? How? Is it like this? In deconstruction, the convergences and divergences between speeches stand out. Then it represents the analysis of a concrete existential situation and their decomposition, i.e. the passage from abstract to concrete, from part to whole, and, then, it goes back to the parts. All this to reach a critical level of knowledge, starting from the subject's experience with regard to her situation within her real context.
- The reconstruction and possibilities of the viable unprecedented things: this moment means the union between new kinds of knowledge and the reality to be apprehended. One seeks the possibilities of viable unprecedented things. This is a practical proposition for overcoming, at least in part, the oppressive aspects perceived at the dialogic moment, when the researcher/facilitator thinks along with the subject the alternative for solving problems pointed out by him. Together, they identify intervention strategies able to overcome the situations generating conflict.⁹

Eight parturients participated in the study, who met the inclusion criteria: being hospitalized in the Obstetric Center and at early labor. Adolescent parturients were excluded. The mothers who participated in the study presented the following profile:

1. Mother₁ – 27 years, complete High School education, married, and housewife. First pregnancy and, according to reports, it was a very desired and healthy pregnancy. Admitted to hospital with 6 cm of cervix dilatation. She remained communicative and cooperative throughout labor and, despite fear and pain, she evolved to normal delivery.

2. Mother₂ — 28 years, married, primiparous, admitted without cervix dilatation, with ruptured bag, wished to give birth through the vagina, but evolved to cesarean section due to dystocia.
3. Mother₃ — 19 years, doesn't work, primiparous, admitted with 5 cm of cervix dilatation. Initially uncooperative, but participatory in dialogues. Her facial expression was painful and fearful, she evolved to vaginal delivery.
4. Mother₄ — 18 years, performed pre-natal care in a private service and she was psychologically prepared for cesarean section, although she presented good performance in labor. Due to her tension, she had elevated blood pressure, requiring drug intervention. There was difficulty to maintain a dialogue and only after her dilatation evolved to 9 cm the parturient started collaborating to vaginal delivery.
5. Mother₅ — 30 years, second pregnancy, admitted with ruptured bag and history of previous cesarean section 1 year and 7 months ago. She arrived psychologically prepared to undergo surgery, believing she couldn't vaginally deliver. When monitoring the labor progress one indicated cesarean section.
6. Mother₆ — 22 years, primiparous, she works as a teacher's assistant, referred with ruptured bag and without contractions, arrived weepy and too scared to be in a different environment and feeling alone. She evolved to cesarean section in the next day.
7. Mother₇ — 26 years, married, housewife, third pregnancy, two vaginal deliveries; she was communicative verbalized fear of labor due to contractions different from those in previous childbirths; she accepted the guidelines suggested, asked questions, and quickly evolved to vaginal delivery.
8. Mother₈ — 22 years, primiparous, observer, and participatory. The wish to give birth vaginally helped a lot during labor.

Five women evolved to normal delivery and three underwent cesarean section due to physiological reasons of pregnancy. Among participants, two were admitted decided to undergo surgical childbirth, one due to

previous history of cesarean section and another willingly.

Initially, a survey of sociodemographic data was conducted in the medical records and, later on, women were approached by the researcher, using a dialogic perspective on an individual basis, being guided by the following questions: What does this moment mean for you? What are your feelings right now? And what are your main needs? For this, one used a voice recorder and a camera, as elements for recording the information provided by the subjects, and education tools, such as video, music, pictures, and posters for helping in discussion and deconstruction of concepts, such as pictures of pregnant women in various situations, as suggested by Paulo Freire's methodology. The use of these kinds of instrument, besides favoring greater awareness of the total information collected, avoids misinterpretations during information analysis and, for this, one used Bardin's Content Analysis.¹⁰

The content analysis was conducted through three stages: the first moment is pre-analysis, which corresponds to the period in which the material is organized, and it aims to make the initial ideas operational and systematic, driving the development of successive operations, taking the analysis into account. The second moment is material exploration, it's the implementation of decisions made in the pre-analysis. The coding time — when raw data is processed in an organized way and gathered into units, which allow a description of the relevant characteristics of content. And in the third moment takes place the processing of results obtained and its interpretation, a time when one develops inferences and interpretations, according to the goals set forth or related to new findings from the research.¹⁰

When analyzing the data collected through the dialogical approach with the parturients two categories emerged: significance of the mothers' childbirth moment and needs felt by parturients during labor.

Since it's characterized as a research involving human beings, it was submitted to the Research Ethics Committee of Universidade Federal do Ceara (UFC), where it was approved under the CAEE 0013.0.039.000.10, as it complied with the principles of Resolution 196/96, from the National Health Council. The free and informed consent term was signed by the parturients, preserving the anonymity guarantee. The study subjects were identified through the word "Mother" followed by a

number, which represents the order of speeches: Mother₁, Mother₂...

RESULTS AND DISCUSSION

• Significance of the mothers' childbirth moment

The feelings related to delivery which predominated among mothers were fear, anxiety, joy, lack of information, and lack of confidence, loneliness, abandonment, and lack of prepare, according to the speeches below:

I'm anxious to have my baby in my arms, but I arrived scared of pain and the people who would care for me, [...] my mother said I had to force and obey the nurses, or they would get angry and leave me alone there. (Mother₂)

I feel alone [...] I'm dying in pain and you stay there, only seeing and doing nothing; I know I can't give a normal birth [...]. (Mother₄)

It seems that walking helps, indeed, the baby to descend, I thought that at labor we couldn't walk nor sit [...] just lie down, it was this way at the two previous births and no one said anything to me. (Mother₇)

According to the World Health Organization, childbirth started being experienced as a moment of intense physical and moral suffering. The parturients' fear, tension, and pain in this care model hinder the physiological process of normal childbirth, something which culminates in interventionist practices that, in most cases, could be avoided. On the part of the Ministry of Health there's an incentive to conduct normal delivery and minimize caesarean sections.¹¹

The feelings revealed showed to be in line with those found in current researches: fear of rapid and unnecessary separation from the newborn infant; of being alone; of the childbirth pain; of the newborn infant's vital conditions; of unexpected problems in childbirth; of the quality of care, characterized by the professionals' lack of attention and respect. This lack of confidence arises from the myths and fears influenced by multiple factors going beyond the physiological evolution of pregnancy itself. Pregnant women live along with the ambiguity of joy for knowing their child and the fear of giving birth, generated by personal life experiences, the childbirth stories heard or experienced with a relative or close friend, information from health professionals and so many others, accessed from all sources available.¹²

One identified in the speech of Mother₂ a concern about her behavior in face of the

health professionals at delivery time, in accordance with warnings by relatives.

The contrast enabled by beliefs and values, in different spheres, doesn't allow the person to exercise the doubt and speech which gives rise to the submission observed in childbirth. The women are unaware of the way how their body works, their rights and limits experienced at this moment, reinforcing their dependence on another individual, represented by the health professional. Thus, the professionals need to change their attitudes towards care, appreciating the parturient's needs and those of her family, resuming the affection bond, recognizing childbirth as an unique and peculiar experience, special, which arouses different feelings and needs.¹³

This individual's freedom to decide requires her to be active and accountable, since there's a need to get convinced that this fight requires her full responsibility.⁹

The feelings revealed by these parturients are a result from a poor education process during the prenatal monitoring, without adequate guidance on the issue, both on the childbirth phases, the bureaucratic procedures, and the pregnant woman's rights, causing tension to the parturients.

The opportunity of exchanging knowledge and experiences on the childbirth stages, of becoming familiar with a similar environment to childbirth, of expressing feelings and fears, knowing experiences and thinking through situations similar to one's own allowed the participants, by collectively constructing knowledge, to strengthen their personal resources, re-elaborate their understanding on the childbirth process, choose healthy alternatives to experience the process and, also, have means for overcoming constraints and opportunities to participate in an active and safe manner.¹⁴

Health education is one of the major elements of health promotion, constituting a political process and pedagogical process which leads to the development of a critical and reflective thought and to the human being's autonomy, by enabling the construction and production of a kind of knowledge which provides this human being with the ability to propose changes and decide on matters related to her care, care for her family, and care for the collectivity.¹⁵

Based on Freire, one believes that the strategy put into practice from the dialogic, reflective, and critical perspective may be effective. It's an instrument for the formation of an enlightened consciousness and, thus,

it'll enable an understanding on the evolution of humanized delivery, aiming at its autonomy and safety.

• Needs felt by parturients during labor

The needs related to the delivery process that predominated in the interviewed were the wish for a companion and privacy, as evidenced in the speeches below:

I feel isolated from the world; I cried a lot when I was told I couldn't stay with my mother nor use a cell phone. (Mother₈)

I wish my mother or my husband was here [...] I would feel more confident, I would have a word of comfort, support. (Mother₆)

I would like to have some privacy at this time, I think it's a very intimate moment to be seen by other women; one seeing the other's suffering and even the delivery. (Mother₇)

Regarding the absence of a companion, one observes, in the speeches, the distress and the need for having some company, caused by the absence of relatives after admission to the obstetric ward.

The Law 11,108/2005, which amended the Law 8,080/1990, provides parturients with the right to the presence of a companion during labor, delivery, and the immediate postpartum period, within the Unique Health System (SUS). The companion chosen by the woman must reflect a relationship involving trust, intimacy, and emotional support, she/he can be her partner, a female friend, her mother, or other person she trusts.^{1,16}

On this regard, the Ministry of Health recognizes the benefits and the lack of risks associated to the presence of a companion, and it recommends that every effort should be made to ensure that all parturient have a person she chooses in order to encourage her and provide her with comfort during the whole childbirth process.¹⁶ Studies indicate the importance of a companion along with the pregnant woman at the delivery time.^{12,17}

Hindering the presence of a companion during labor and delivery violates the woman's right as a Brazilian citizen. Furthermore, this violates her own autonomy, her capacity for choosing, opting for the presence or absence of a companion, choosing the person she wishes to be by her side at this moment.¹⁸

In a study one found out that pregnant women and their companions wish to prepare themselves to negotiate care procedures and the modalities of delivery without feeling intimidated due to the professional's knowledge.¹⁹ Thus, it's important that this prepare takes place since the prenatal care, when the pregnant woman points out her

companion and she/he can be informed about the childbirth process.

Regarding the lack of privacy experienced by pregnant women, the major highlight for most participants was due to the inadequate physical environment, which doesn't meet the needs for preserving the female body shame, going against the humanization idea, due to the fact of causing an increased tension to the woman, especially to those women who experience a strict culture when it comes to intimacy.

Privacy is needed by the woman in the childbirth process, which involves hormonal releases, leading the pregnant woman to relieve pain and shorten parturition time.²⁰

FINAL REMARKS

A scientific study carried out under the shape of investigation of a given reality requires a maturity from the researcher forged by the construction of new kinds of knowledge, fruits of the acquisition of new information from the awareness-based reflection/action process, from the transforming perspective.

In this understanding, there's a need for knowledge exchange, in order to overcome the mere speculation or veiled denunciation of problems identified. Taking into account Paulo Freire's thought, to which one resorted to provide the study with a basis, one emphasizes the dialogue and participation as a crucial condition for the transforming action with regard to the humanization of delivery and birth.

Through the dialogue with a curious presence of the subject, in face of reality and an intervening action over reality to transform it, the results of this study should enable the promotion of greater participation of subjects (professionals and parturients) for the collective construction of alternatives to overcome the delivery practices going against the humanization of birth.

This way, some basic ideas are presented below, extracted from our understanding through the studies conducted on the humanization of delivery:

- The presence of a companion along with the parturient in the delivery process, the parturient's well-being, and the birth of a healthy child depends on trust in the professionals who care for her. Labor pain is a physiological mechanism which aims at the expulsion of the fetus, one can't encourage parturients to change, without an understanding of their culture and

interpretation with regard to the delivery process. Privacy preserves the female body shame and multidisciplinary becomes relevant in integral care for the parturient.

Finally, we take the liberty of making some recommendations we consider crucial to better qualifying the actions undertaken in the institution: continued training of professionals involved in the institution's maternity with regard to humanized delivery; the parturient's embracement through a dialogic behavior; the need for an adequate physical structure, in order to provide greater privacy; acquisition of materials which improve the delivery time.

Therefore, it'll be possible to perform a health care based on the humanization of delivery, decreasing the routine practice of invasive methods, something which makes delivery more painful and less natural. Changes aimed to improve care for the parturient will result in an increased number of normal deliveries, the option of choice for women, thus decreasing the caesarean sections rate and ensuring reduced risk for the binomial mother/child.

The parturient's autonomy is of great value for the effectuation of humanized delivery, for this, there's a need that health professionals recognize it as active participants in the process and welcome it ruled by active listening and by the possibility of providing a space for dialogue.

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Submission: 2012/10/07

Accepted: 2013/04/06

Publishing: 2013/05/01

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