HUMANIZATION POLICY OF LABOR ASSISTANCE BASED ON REDE CEGONHA IMPLEMENTATION: INTEGRATIVE REVIEW

POLÍTICA DE HUMANIZACIÓN DE LA ASISTENCIA AL PARTO COMO BASE A LA IMPLEMENTACIÓN REDE CEGONHA: REVISIÓN INTEGRADORA

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ABSTRACT

Objective: to analyze the humanization policy of childbirth care in the literature, as a basis for the implementation of the Rede Cegonha. Method: this is an integrative review, to answer the guiding questions << What is the scientific evidence about the humanization policy of childbirth and birth care as a basis to implement the Rede Cegonha? Does the insertion of the terminology “Rede Cegonha” in DeCS represent an ease way to show the literature on the political approach to humanizing childbirth? >>. The search for scientific production, between 2000 and 2015, was carried out in the LILACS, MEDLINE and SCIELO virtual libraries. For the analysis of the articles, it was sought the center of meaning that composes the corpus of scientific analysis productions. Results: there were 18 articles found, no study was identified when using the descriptor “Rede Cegonha,” which was inserted in the DeCS from this study. Conclusion: there were challenges related to the implementation of the Rede Cegonha that interfered with the guarantee of quality assistance. Descriptors: Humanized Birth; Obstetric Delivery; Maternal and Child Nursing; Prenatal Care.

RESUMEN

Objetivo: analizar la literatura a política de humanización de asistencia al parto y nacimiento como base a la implementación de la Rede Cegonha. Método: revisión integradora, con vistas a responder las preguntas norteadoras << Cuáles son las evidencias científicas sobre la política de humanización de asistencia al parto y nacimiento como base para implementar a Rede Cegonha? A inserção da terminologia Rede Cegonha, nos DeCS, representa facilidad para evidenciar, en la literatura, a abordagem política do parto humanizado?>>. Realizou-se busca da produção científica, entre 2000 e 2015, nas bases de dados LILACS, MEDLINE e biblioteca virtual SCIELO. Para análise dos artigos, buscou-se os núcleos de sentido que compõem o corpus de análise das produções científicas. Resultados: 18 artigos encontrados, nenhum estudo foi identificado quando se utilizou o descritor “Rede Cegonha”, o qual a partir deste estudo foi inserido nos DeCS. Conclusões: evidenciou-se desafios relacionados à implementação da Rede Cegonha que interferem na garantia da asistencia de calidad. Descriptores: Parto Humanizado; Parto Obstétrico; Enfermagem Materno-Infantil; Cuidado Pré-Natal.

RESUMEN

Objetivo: analizar en la literatura, la política de humanización de asistencia al parto y nacimiento como base a la implementación de la Rede Cegonha. Método: revisión integradora, para responder a las preguntas guiaroras << Cuáles son las evidencias científicas sobre la política de humanización de asistencia al parto y nacimiento como base para implementar la Rede Cegonha? La inserción de la terminología Rede Cegonha, en los DeCS, representa facilidad para evidenciar, en la literatura, el enfoque política del parto humanizado?>>. Realizada la búsqueda de la producción científica, entre 2000 a 2015, en las bases de datos LILACS, MEDLINE y biblioteca virtual SCIELO. Para análisis de los artículos se buscaron los núcleos de sentido que componen el corpus del análisis de producciones científicas. Resultados: 18 artículos encontrados, ningún estudio fue identificado cuando se utilizó el descriptor “Rede Cegonha”, el cual a partir de este estudio fue inserido en los DeCS. Conclusión: se evidencian desafíos relacionados a la implementación de la Rede Cegonha que interfieren en la garantia de la asistencia de calidad. Descriptores: Parto Humanizado; Parto Obstétrico; Enfermería Materno-Infantil; El Cuidado Prenatal.

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INTRODUCTION

The humanization of childbirth and birth aims at reducing maternal and neonatal morbidity and mortality by overcoming the technocratic model by the humanist, in which the parturient is the protagonist in childbirth, valuing the physiological and psychological process of parturition.¹

The women’s health policy was redesigned in 2011 through the Administrative Rule No. 1459 of June 24, 2011, in which the Federal Government instituted the Rede Cegonha within the scope of the SUS that established guidelines to be implemented in the care of pregnant women. It reaffirmed the humanized care model to normal childbirth and the child up to two years old, among other objectives.²

The Rede Cegonha mandates that health services adopt safe practices in delivery and birth care, as well as increasing the availability of obstetric and neonatal beds. In this structural and organizational redesign to be implanted in a gradual manner throughout the national territory, priority is given to regions included in the epidemiological criteria of the high caesarean rates, infant mortality, maternal mortality ratio and population density.³

The Rede Cegonha is composed of four main components: prenatal; childbirth and birth; puerperium and childcare; and the logistic system.⁴ The implementation of this system covers actions from prenatal care in the Basic Health Care, maternity hospitals and hospitals linked to the Unified Health System (SUS). Pregnant women at normal risk are monitored at basic health units, and when diagnosed with risk or labor complications, they are sent to recommended secondary care services, being mandatory to have an efficient regulation service to meet the demand of the population.¹⁻⁵

To meet the great demand of patients in Brazil, the insertion of the nurse in the Rede Cegonha is fundamental to the implementation of actions in basic care. Quality in childbirth care and humanized teamwork favors the guarantee of women’s rights.⁶

In a positive way, the information contributes to preventing risks and complications in the puerperium and to achieve success in breastfeeding. Thus, health professionals must take the position of educators who share knowledge, contributing to the empowerment of women and self-confidence to fully live gestation, childbirth and the puerperium.⁶,⁷

OBJECTIVE

- To analyze the policy of humanization of childbirth and birth care in the national literature based on the implementation of the Rede Cegonha.

METHOD

This is an integrative review study, a tool that synthesizes the results of previous research and shows the conclusions about a specific phenomenon and several studies related to the guiding questions of the research.⁸

For the development of the review, six stages were carried out: the first stage was the definition of the guiding questions of the research; in the second stage the inclusion and exclusion criteria were delimited; in the third stage the databases were chosen, and the search for the productions was carried out; in the fourth stage the analysis of the 4 data was performed; in the fifth stage the data discussion was developed; and in the sixth stage the synthesis of the review was presented.

The guiding questions of the study were: What is the scientific evidence on the humanization policy of childbirth and birth care based on the implementation of the Rede Cegonha? Is the insertion of the terminology “Rede Cegonha” in the Descriptors in Health Sciences (DeCS) an easy way to show the literature on the political approach to humanizing childbirth?

Thus, the inclusion criteria used were: articles that provided the full text, articles with the online version for free, national and international productions, published in Portuguese. The time frame delimited were 2000 to 2015 to show the current scientific production. Theses, dissertations, monographs and articles that after reading the abstract did not converge with the proposed study object and the publications that were repeated in the databases were excluded.

The search was carried out by two reviewers, ensuring rigor to the selection process of the articles in the databases in the health area Latin American and Caribbean Literature in Health Sciences (LILACS); Medical Literature Analysis and Retrieval System (MEDLINE) and Scientific Electronic Library Online (Scielo), in September 2015 with keywords standardized and available in DeCS: “humanized delivery” [and] “obstetric delivery” [and] “maternal-infant nursing” [and] “prenatal care”.

English/Portuguese

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After reading the titles and abstracts, the selected studies were analyzed using an already validated instrument, evaluating data regarding the identification of the original article, methodological characteristics of the study, evaluation of the methodological rigor, the interventions measured and the results found in the articles to the journal, author, study and level of evidence\(^5\): 1 - systematic reviews or meta-analysis of relevant clinical trials; 2 - evidence of at least one well-delineated randomized controlled trial; 3 - well-delineated clinical trials without randomization; 4 - well-delineated cohort and case-control studies; 5 - systematic review of descriptive and qualitative studies; 6 - evidence from a single descriptive or qualitative study; 7 - opinion of authorities or committees of experts including interpretations of information not based on surveys.\(^10\)

The following steps were established after searching the articles: 1) Evaluation of titles and abstracts. When the title and/or abstract were not enlightening, the article was searched in its entirety, avoiding leaving important studies of this review absent; 2) Full reading of articles that after reading the abstracts obeyed the inclusion criteria.

In the first stage of search 601 articles were found and, after applying the inclusion criteria with evaluation of titles and abstracts, 68 were selected to read the abstracts. Of them, 34 were chosen for reading in full; the remainder was discarded for addressing subjects that did not meet the study objective. After the in-depth evaluation of the texts, 18 articles were selected to interpret the data in full and present their results, as they answered the objectives of this research.

### RESULTS

The results showed that 10 titles (55.5%) of scientific publications focused on prenatal care, six (33.3%) on the humanization of childbirth and birth, and two (11.2%) on maternal or infant mortality.

Regarding the time frame of the studies, 2013 and 2010 were a highlight, respectively, with 5 (27.8%) and 3 (16.4%) of the findings each. Followed by 2011, 2012, 2014 with two findings (11.1%) and 2002, 2005, 2006 and 2008, with one article (5.5%), it is observed that most articles, (83.3%) presented level of evidence IV; while 1 (5.5%) was review, 1 (5.5%) level of evidence III; and another with level of evidence VI (5.5%), according to Figure 1.

<table>
<thead>
<tr>
<th>Authors</th>
<th>Title</th>
<th>Journals</th>
<th>Year</th>
<th>Category</th>
<th>Level of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4</td>
<td>Narchi NZ</td>
<td>Prenatal care by nurses in the East Zone of the city of São Paulo, Brazil.</td>
<td>Revista Escola Enfermagem USP</td>
<td>2010</td>
<td>Prenatal IV</td>
</tr>
<tr>
<td>A6</td>
<td>Oliveira RLA, Fonseca CRB, Carvalhaes,</td>
<td>Evaluation of prenatal care from the perspective of</td>
<td>Revista Latino-Americana Enfermagem</td>
<td>2013</td>
<td>Prenatal IV</td>
</tr>
</tbody>
</table>
Figure 1. Articles found in the databases of the health area from 2000 to 2015. Goiânia (GO), Brazil, 2015.

It was observed that all studies analyzed are national. As for the state of origin, it was observed that most of the productions are from the state of São Paulo, with a total of five articles (27.8%), being a research carried out in this state, concomitantly with the city of Lisbon, in Portugal; followed by Minas Gerais and Rio Grande do Sul, with three...
articles each (16.4%); then, the states of Ceará, Paraná, Pará, Santa Catarina, Rio de Janeiro represented by an article (5.5%). There is also a study (5.5%) of national coverage, as can be observed in Figure 2.

<table>
<thead>
<tr>
<th>States</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>São Paulo</td>
<td>A4 - A6 - A11 - A13 - A14</td>
</tr>
<tr>
<td>Minas Gerais</td>
<td>A3 - A7 - A18</td>
</tr>
<tr>
<td>Rio de Janeiro</td>
<td>A12</td>
</tr>
<tr>
<td>Rio Grande do Sul</td>
<td>A1 - A2 - A16</td>
</tr>
<tr>
<td>Paraná</td>
<td>A8</td>
</tr>
<tr>
<td>Santa Catarina</td>
<td>A15</td>
</tr>
<tr>
<td>Pará</td>
<td>A9</td>
</tr>
<tr>
<td>Ceará</td>
<td>A5</td>
</tr>
<tr>
<td>São Paulo/Lisbon (Portugal)</td>
<td>A10</td>
</tr>
<tr>
<td>National coverage</td>
<td>A17</td>
</tr>
</tbody>
</table>

Figure 2. Articles analyzed according to the state of origin. Goiânia (GO), Brazil, 2015.

Regarding the research subjects, it was observed that four of the articles (22.2%) had the nurse as object of study; one article (5.5%) studied this professional and the nursing team completely; three articles (16.4%) had postmenopausal women, two articles (11.1%) had the participation of pregnant women, and one article (5.5%) studied parturient women. Also, there was a medical record analysis, where two studies (11.1%) used this methodology, a study (5.5%) also used the joint analysis of medical records with available physical resources and physical space of the institution under study. Another study correlated the data contained in the medical records and those collected with the participation of the puerperal woman (5.5%), and another study correlated these data from the medical records with the analysis of the physical space and the participation of the managers of the units under study (5.5%). It should be noted that there was a study of reflection and an integrative review of the literature, as shown in Figure 3.

<table>
<thead>
<tr>
<th>Articles</th>
<th>Object of study/ Subject of research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>A4 - A5 - A7 - A12</td>
</tr>
<tr>
<td>Nursing team</td>
<td>A14</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>A3 - A10</td>
</tr>
<tr>
<td>Parturient women</td>
<td>A8</td>
</tr>
<tr>
<td>Puerperal women</td>
<td>A1 - A11 - A16</td>
</tr>
<tr>
<td>Medical records analysis</td>
<td>A2 - A18</td>
</tr>
<tr>
<td>Medical records analysis/Puerperal</td>
<td>A17</td>
</tr>
<tr>
<td>woman</td>
<td>A13</td>
</tr>
<tr>
<td>Medical records analysis/material and physical resource</td>
<td>A6</td>
</tr>
<tr>
<td>Medical records analysis/physical space/Managers</td>
<td>A15</td>
</tr>
<tr>
<td>Review</td>
<td>A9</td>
</tr>
<tr>
<td>Reflexive study</td>
<td>A15</td>
</tr>
</tbody>
</table>

Figure 3. Correlated articles with their subjects and objects of research

Figure 4 shows the objectives of the studies analyzed and a brief synthesis of the results obtained in them.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Knowing the perception of puerperal women about prenatal care</td>
</tr>
<tr>
<td>A2</td>
<td>Identifying the characteristics of the pregnant women attending a prenatal nursing visit performed by an obstetric nurse in an outpatient clinic, and</td>
</tr>
</tbody>
</table>
The family health strategy (ESF) obtained better results than the Center for Care and Maternal and Child Care (CEAAMI) in all indicators. The first consultation indicator performed up to 120 days reached 91.7% in the ESF and 88.2% in the CEAAMI. The number of examinations performed up to 120 days is higher in the ESF than in CEAAMI. There was a statistically significant difference for glycaemia and toxoplasmosis tests. At the ESF, 92.7% of the pregnant women had six or more consultations. In CEAAMI, this indicator reached 78.4%.

The results showed that nurses do not exert the essential competence for qualified prenatal care because of the personal and institutional barriers they face in their work. Thus, it is perceived the need of public health structures to revise their policies to ensure the implementation of SUS guidelines regarding the improvement of maternal and child health care and the allocation of human and financial resources in this direction.

Four of the fourteen health centers investigated showed adequate indicators for prenatal care. However, although there are inadequacies in the physical structure, there are no impediments to the provision of quality care since the process, and the results also interfere with the quality of care.

Similar structures were found in both care models. Indicators-process synthesis, created in this study, and those indicated by public policies pointed to a more favorable situation in the Family Health Units. For the set of activities recommended for prenatal care, performance was poor in both models, although little better in the Family Health Units.

The results demonstrated the need for investments in the training of qualified personnel to care for women in the pregnancy-puerperal cycle, as well as the creation and incorporation of protocols that promote a better interaction of medical and nursing work.

The sociodemographic and obstetric characteristics of parturient women and newborns were not associated with the onset of prenatal care, as well as the verification of weight, blood pressure, prescription of folic acid and ferrous sulfate, and biochemical tests were associated with the onset of an adequate prenatal care. The essential procedures during the consultations are performed inadequately, even those considered simple, bringing greater risks to pregnant women and the newborn.

After a thematic analysis of the content of the productions, two dimensions were obtained: the socio-maternal and the socio-caring. The socio-maternal dimension considered the social representations of women on gestation, prenatal, normal and cesarean delivery, breastfeeding and joint accommodation. The results revealed the need to explore the common sense of women and integrate them to the scientist so that they autonomously develop care for themselves and the baby.

The analysis of the experiences indicates that the two groups can be considered informative or educational, with methodology and structuring in the form of lectures with pre-defined themes, with reduced possibility of reflection and empowerment, due to the fragmented form of presentation. It denotes diminished reflection about the changes in the female role. It is concluded that the need to care for women, at different times in their lives, presupposes the continuous struggle for a comprehensive approach, emphasizing the care network and the focus on health promotion.

The comparison between the results regarding the satisfaction of women with the care provided by the health professionals, the quality of the care and the reasons for satisfaction and dissatisfaction, with the indication or recommendation of the services received, with a sense of security in the process and with the suggestions for improvement showed that the CPHPH...
| A12 | Describing the criteria used by nurses to indicate the environment of parturient women relaxation and analyzing the meanings of the care performed in this environment for obstetric nurses. |
| A13 | Evaluating the physical infrastructure, material resources, equipment and the assistance provided in the PPP by the Resolution of the Collegiate Board of Directors-RDC 36/2008 of the National Agency of Sanitary Surveillance - ANVISA. |
| A14 | Discussing the perception of the nursing team about the humanization of childbirth and birth. |
| A15 | Aiming at a reflection on the process of parental involvement at the time of childbirth. |
| A16 | Knowing the perceptions of the adolescent mother about motherhood at this stage of life; knowing the adolescents’ perception of the health care provided by the hospital staff; and knowing how they would like to care during the maternity period. |
| A17 | Analyzing the profile of the neonatal deaths identified in the Born in Brazil national survey and the associated factors, considering the socioeconomic and demographic contextual aspects, the characteristics of the pregnant woman and the newborn and the care process in the prenatal, delivery and birth. |
| A18 | Analyzing the social determinants involved in this event, the reproductive profile of these women, the accessibility and quality of health services from the data of the Maternal Mortality Prevention Committee of Juiz de Fora. |

The model was the best evaluated, followed by the CPNIH model and finally the Typical model. It was concluded that the peri-hospital model of childbirth care should receive greater support from SUS since it is a service in which women are satisfied with the care received.

This study identified that the relaxation environment is used by nurses for women who have low-risk pregnancies and experience intrinsic and extrinsic stressors during labor. Intrinsic factors can be triggered by the emotional state of the parturient woman, such as pain and anxiety. Extrinsic factors are generated by the prepartum environment, which can cause insecurity, fear, fatigue, among others, resulting in the absence of adequate conditions for comfort and privacy.

The results show that the physical infrastructure, materials, and equipment are by the resolution. The care was classified as good by the analysis of the indicators: the presence of a companion, use of non-pharmacological methods for pain relief, breastfeeding and immediate mother-child contact at childbirth. Despite this, the team’s care is recommended for the continuation of the parturient woman in the three periods of delivery in PPP and the lactation and immediate contact of the newborn with the mother, since this CO will only have PPP rooms.

Through the testimonies of the nursing professionals, a differentiated view on the humanization of childbirth and birth was observed. While maternity professionals focus on humanization only on the issue of not using drugs or making interventions at the time of childbirth, birthing professionals focus on the issue of respect for women by establishing care focused on their wishes and choices.

It is opportune to discuss the issue of parental involvement in the process of birth and in the family context in the face of the dimension that this theme has acquired in recent times, mainly due to the changes that have been taking place in the modern world to the transmission of violence, a child who has a violent or careless father builds an unpredictable and unrewarding worldview. Men, whether adults or adolescents, need to be included in the work developed. Regarding the adolescents’ perception of the health care provided by the hospital staff, all were satisfied with the perinatal care performed. Since most of the participants are experiencing hospital admission for the first time, the method found to classify the care provided by the institution was through comparison with other hospitals, where they were attended during gestation, pointing out positive aspects of the hospital care where they performed the childbirth.

The mortality rate was 11.1 per thousand; Higher in the North and Northeast regions and lower social classes. Low birth weight, gestational risk, and newborn conditions were the main factors associated with neonatal death. Inadequate prenatal and delivery care indicated the unsatisfactory quality of care. The pilgrimage of pregnant women for childbirth and the birth of children weighing <1,500 g in a hospital without a neonatal ICU showed gaps in the organization of the health network. Deaths of term newborns by intrapartum asphyxia and by late prematurity express the avoidance of deaths.

The Maternal Mortality Ratio (RMM) between 1996 and 2001 was 98.5 per 100,000 live births, rising over the next six years (2002 to 2007) to 77.8 per 100,000 live births. An association between a number of antenatal visits and color (p<0.02) and correlation (r=0.90, p-value=0.01) were found between areas of social exclusion and number of maternal deaths.

Figure 4. General objectives of the articles and their results. Goiânia (GO), Brazil, 2015.
Alves AG, Martins CA, Lima e Silva F et al.

Health Strategy presented a superior qualification when compared to a tertiary unit of maternal and child care. However, the authors revealed that it is necessary to increase this type of care since it covers only 40% of the population of the municipality under study.13

Another descriptive-exploratory quantitative study analyzed prenatal nursing care in the East Zone of São Paulo, identified that the nurses in the unit experience institutional and personal difficulties in the development of skills essential to care. This situation affects the effective implementation of programs already enrolled in SUS, such as the Rede Cegonha and compromises the quality of care offered.14

A study carried out in Ceará verified that the Family Health Centers of the municipality rely on the effective performance of nurses in prenatal care. However, there were difficulties regarding the unavailability of sufficient financial resources for quality infrastructures such as sinks, screens, consulting rooms, spaces for health education activities and PPEs. There was also a small availability of other supplies for the provision of care, access to fundamental laboratory tests in prenatal care, such as uricoculture with antibiogram, proteinuria, and anti-HIV test. It is worth mentioning that of the four Family Health Centers evaluated, one of them did not have adequate physical structure, evidencing that the challenges related to the environment do not prevent quality care.15

Thus, it is inferred that material resources and adequate physical structure are important to the achievement of prenatal goals, providing quality care to the patients of the service. Because of this, the physical space is seen as a mechanism that facilitates the assistance and guarantees a humanized, welcoming and resolutive service.

Another study showed that, in the primary care units, those that incorporated the ESF presented better results regarding the quality of prenatal care performed in comparison to the primary care units, with the physician being the main agent in the process. In the ESF, the nurse’s performance stands out with autonomy, so that prenatal care is configured as a joint action of the two professional categories.16

Another study that sought to know the nurses’ perception about the use of the protocol adopted in the basic health unit evidenced that the professionals perform the recommended actions as a way to provide safety in the exercise of their functions since it regulates and supports the nursing...
From international trends, a study presents a comparative analysis between the assistance models regarding the integrity of maternal health care adopted in Brazil and Portugal, based on the experience of the authors in both contexts and the observation of two groups of pregnant women, one in each country. It was observed that in both countries the passive methodology of teaching predominated, with a small reflection on the subjects addressed, as a result of the pre-definition of the subjects to be addressed without taking into account the needs of the patients and the limited number of meetings prejudicing the contribution to the empowerment of pregnant women.

Humanization of childbirth and birth

One study compared the satisfaction of women about labor in birth centers, in-hospital normal birth center, and in traditional obstetric centers, and found that satisfaction was highest among postpartum women who experienced this time in birth centers. This is because the model is less interventionist, with the active participation of the patient, as well as the presence of a companion.

Concerning a specific health unit that established a relaxation environment for laboring mothers, a survey identified that the obstetrical nurses responsible for this service understand this care as important for the humanization of the parturition process.

Another study sought to verify the adequacy of the structure and assistance offered in a pre-delivery, delivery and immediate postpartum room and showed that there were irregularities regarding physical structure, material resources, and equipment, but there was no negative influence on the care provided since it was evaluated as “good” by the authors.

This fact emphasizes what has already been discussed regarding the importance of the professionals’ performance to the detriment of the consonance of the environment and the available inputs.

A study verified that nurses working in maternity hospitals presented a vision of humanization of the strict pregnancy-puerperal process, focusing only on the non-use of drugs and avoiding unnecessary interventions at the time of delivery; while professionals working in birth centers demonstrated a concern about respect for the woman patient, an assistance centered on her wishes and her choices. The authors attribute the findings to the fact that the nurse occupies a passive position in the care of institutionalized delivery, while in the context...
of the birth centers, they have autonomy throughout the pregnancy-puerperal period.\textsuperscript{24}

Another important aspect of humanization in the parturition process was addressed in research about the importance of the father’s participation in this process and concluded that the inclusion of the paternal figure contributes to the humanization of care.\textsuperscript{25}

It is noted that many times this right is not put into practice by the complete ignorance of the parturient who was not properly informed during the prenatal period. This is the moment in the gestation to resolve doubts, clarify prejudices and annul the expectations of the pregnant woman, guaranteeing her the explanation of all the advantages that it ensures.

A study that analyzed the complexity of motherhood in adolescence found that it is possible to achieve humanized and individualized care based on the satisfaction of pregnant women related to differentiated care. They reported that they were adequately oriented and perceived the professionals’ concern to alleviate their suffering during labor, reaffirming that the technique without a humanized look is distant from the conception of health care desired by the patients.\textsuperscript{26}

The humanization of care for the pregnancy and the puerperal period is advantageous for mother-child, both from the reduction of morbidity and mortality rates and from respect, dignity, and satisfaction of the patients. Nevertheless, there was no adherence of the Rede Cegonha in its entirety and all the localities of the country, especially when performing the delivery in peri-hospital environments, so that the birth centers constitute an exception to the Brazilian reality. However, it is possible to find emergency measures that seek to bring assistance closer to what is advocated by public policies.

Maternal and neonatal mortality - evaluation of care

A study analyzing the profile of neonatal deaths in Brazil showed that prematurity associated with low birth weight, followed by congenital malformations, the main cause of neonatal deaths. Associating this fact with the increase of prematurity, observed during the study, the importance of prenatal care was evidenced, especially for its prevention actions through the control of congenital infections and the risks in pregnancy, and prevention of iatrogenic prematurity, mainly that is related to the undue interruption of gestation. The adoption of the Rede Cegonha already presents positive and expressive results regarding the reduction of preventable deaths, although it has not yet been implemented and widely in force in the national territory.\textsuperscript{27}

In addition, the puerperal satisfaction with humanized care highlights greater safety and reduction of infant mortality rates, as intrapartum asphyxia is another cause of preventable and frequent neonatal death and it is interconnected with attention to labor and birth, and it involves measures ranging from the prevention of problems related to intra-uterine hypoxia in the prenatal period to the eradication of the delay of adequate interventions within health services, which could prevent 36% of labor-related deaths.\textsuperscript{27}

It was also verified that there are serious failures in parturition care, related to non-adherence to good practices in labor and delivery, recommended by the WHO, use of partograph, vertical position in prepartum, and unnecessary and/or not recommended interventions by the literature, such as: Kristeller’s maneuver, lithotomy position at birth, abusive use of oxytocic, bed immobilization, among others.\textsuperscript{27}

A study that analyzed the social determinants involved in motherhood observed that the number of prenatal consultations is related to the maternal mortality rate. In addition, the majority of the maternal deaths identified were of the direct obstetric type, those that are due to obstetric complications during the pregnancy-puerperal cycle, and are mostly avoidable, which refers to the need to ensure integral and quality care to the woman.\textsuperscript{28}

CONCLUSION

In this study, it was evidenced that the implementation of the Rede Cegonha has challenges as the policy of humanized assistance to women in the puerperal pregnancy period: education actions to the pregnant woman, lack of orientation regarding the rights of the pregnant woman, the physical structure/inadequate environment that hinders the attendant participation in the process of parturition and the quality of care, the functioning of the network system is incipient, which can contribute to the professional stress interfering in the guarantee of quality assistance throughout the pregnant-puerperal period of the patient of the Unified Health System.
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