



REFLECTIONS ON THE PROMOTION OF HEALTH IN THE CONTEXT THE PROGRAM HUMANIZATION PRENATAL AND BIRTH

REFLEXÕES SOBRE A PROMOÇÃO DA SAÚDE NO CONTEXTO DO PROGRAMA DE HUMANIZAÇÃO DO PRÉ-NATAL E NASCIMENTO

REFLEXIONES SOBRE LA PROMOCIÓN DE LA SALUD EN EL CONTEXTO DEL PROGRAMA DE HUMANIZACIÓN DEL PRENATAL Y PARTO

Linicarla Fabiole de Souza Gomes¹, Camila Chaves da Costa², Cristiana Brasil de Almeida Rebouças³, Patrícia Neyva da Costa Pinheiro⁴, Neiva Francenely Cunha Vieira⁵, Ana Kelve de Castro Damasceno⁶

ABSTRACT

Objective: to think over the role of health promotion in the context of the Prenatal and Birth Humanization Program. **Method:** a reflective study, conducted from reading articles, manuals of the Ministry of Health, legislation and books. The search was performed by on-line access in March 2011. After reading and summary the literature, we proceeded to descriptive analysis, which contributed to the reflection on the subject. **Results:** the humanized obstetrical attention involves knowledge, practices and attitudes aiming to promote a healthy childbirth and birth. The PBHP adopts humanization in an equity/citizenship context, being health promotion associated with the role of citizens seen as citizens of rights. Health in education corroborates with the empowerment of women in this obstetric experience. Conclusion: the health promotion in the PBHP includes a quality care and humanization, considering the woman as the protagonist of pregnancy and childbirth. It's up to the nurse to reflect over health promotion of the binomial mother and son. **Descriptors:** humanizing delivery; health promotion; health education; nursing.

RESUMO

Objetivo: refletir sobre a promoção da saúde no contexto do Programa de Humanização do Pré-natal e Nascimento. **Método:** estudo reflexivo, realizado a partir da leitura de artigos, manuais do Ministério da Saúde, legislações e livros. A busca de informações foi realizada em março de 2011, pelo acesso on-line que, depois da leitura e fichamento da literatura, procedeu-se a análise descritiva, o que contribuiu para a reflexão sobre a temática. **Resultados:** a atenção obstétrica humanizada envolve conhecimentos, práticas e atitudes que visam à promoção do parto e do nascimento saudáveis. O PHPN adota a humanização em um contexto de equidade/cidadania, tendo a promoção da saúde associação com o protagonismo dos sujeitos vistos como cidadãos de direitos. A educação em saúde corrobora com o empoderamento da mulher nessa vivência obstétrica. **Conclusão:** a promoção da saúde no PHPN contempla uma atenção de qualidade e a humanização, considerando a mulher como protagonista do ciclo gravídico-puerperal. Cabe ao enfermeiro refletir sobre a promoção da saúde da mulher e de seu filho. **Descritores:** parto humanizado; promoção da saúde; educação em saúde; enfermagem.

RESUMEN

Objetivo: reflexionar sobre la promoción de la salud en el contexto del Programa de Humanización del Prenatal y Nacimiento. **Método:** estudio reflexivo, llevado a cabo a partir de la lectura de artículos, manuales del Ministerio de Salud, de la legislación y los libros. La búsqueda fue realizada por el acceso en línea en marzo de 2011. Después de la lectura y resumen de la literatura, se procedió a un análisis descriptivo, lo que contribuyó para la reflexión sobre el tema. **Resultados:** la atención obstétrica humanizada implica conocimientos, prácticas y actitudes para promover un parto y nacimiento saludables. El PHPN adopta la humanización en un contexto de equidad/ciudadanía, estando la promoción de la salud asociada al protagonismo de los sujetos como ciudadanos de derecho. La educación en salud fortalece el empoderamiento de la mujer en esta vivencia obstétrica. **Conclusión:** la promoción de la salud en el PHPN incluye una atención de calidad y humanización, con la mujer como protagonista del embarazo y el parto. Corresponde al enfermero reflexionar sobre la promoción de la salud de la mujer y su hijo. **Descriptores:** parto humanizado; promoción de la salud; educación en salud; enfermería.

¹Nurse. MS in Nursing from the Federal University of Ceará / UFC. Fortaleza (CE), Brazil. E-mail: linicarlafabiole@yahoo.com.br; ²Nurse. MS in Nursing from the Federal University of Ceará / UFC. Fellow FUNCAP. Fortaleza (CE), Brazil. E-mail: mlinha_ita@yahoo.com.br; ³Nurse. Post-doctorate in Nursing from the Federal University of Ceará / UFC. Fortaleza (CE), Brazil. E-mail: cristianareboucas@yahoo.com.br; ⁴Nurse. PhD in Nursing. Assistant Professor II of the Federal University of Ceará / UFC. Fortaleza (CE), Brazil. E-mail: nevyva@ufc.br; ⁵Nurse. PhD in Nursing. I Associate Professor, Federal University of Ceará / UFC. Fortaleza (CE), Brazil. E-mail: nvieira@ufc.br; ⁶Nurse. PhD in Nursing. III Adjunct Professor, Federal University of Ceará / UFC. Tutor Education Program Tutorial PET / SESU / Nursing / UFC. Coordinator of Nursing Research Project on Promotion of Maternal Health. Fortaleza (CE), Brazil. E-mail: anakelve@hotmail.com.br

INTRODUCTION

Pregnancy and childbirth are moments inherent in the female life cycle, establishing itself as a physiological process in which a woman must be the protagonist at all times of these events. Therefore, it is for managers and professionals develop and actualize public policies that guarantee the right to quality care, integral and humanized, and that meets the health promotion of the woman and her child.

Motherhood is one of the most important experiences physical, psychological and intersubjective in women's lives. The childbirth, while episode represents the culmination of physiological and biochemical phenomena, while emotional event, psychological and existential, is the own transcendence itself.¹

Although the process of giving birth is characterized as biological and social, since the nineteenth century, it began to receive a pathological connotation due to the influence increasingly present culture hospital-square that favors the technique medicalized and depersonalized, to the detriment of encouragement, support and care for women who experience them.³

In Brazil, the medicalization of childbirth is increasingly more present; contributing to high rates of maternal mortality and cesarean sections in the country.⁴ The high rates of maternal and infant mortality are characterized as human rights violation and a public health problem. In 2003, the maternal mortality ratio - MMR in Brazil was 51.7 per 100,000 live births (LB), and corrected MMR is 72.4 per 100,000 live births, accounting for 1,572 deaths. As to the causes of death, there predominated direct obstetric, especially hypertensive diseases and syndromes hemorrágicas.⁵

The Infant Mortality Rate (IMR) declined from 47.1 in 1990 to 19.3 in 2007, a reduction of 59%, with a greater decrease in the North and Northeast, however, these regions have the highest levels of infant mortality. The Northeast region in 2007 showed IMR of 27.2 / 1000 NV.⁶ It is noteworthy that perinatal mortality is the most appropriate and used in health services for analysis of obstetric assistance and neonatal. As the component responsible for early about 50% of child deaths, there is a close relationship between infant deaths and birth care and birth, which is predominantly hospital in Brazil.⁷

These maternal and child deaths opposite themselves to the scientific and technological

advances in the areas of maternal and perinatal health in the late twentieth century. Being unacceptable for the reproduction process causes harm to women or their fetuses, or take them to death. The term humanized birth is being used and proposed by the Ministry of Health, however, it is observed that the act of giving birth has ceased to be natural to be a time of excessive medical interventions, taking the woman's right to be the protagonist of this event.

In view of the resumption of natural childbirth, policies of humanization as Program of Humanization of Prenatal and Birth (PHPN) have gained space in the government scene, generating discussion among the social sectors concerned with health care focused on safety and respect for the human rights.⁴

The PHPN aims the development measures of health promotion, prevention and care for pregnant women and newborns, ensuring access, quality and capacity for obstetric and neonatal care,⁸ having as one of its main operations to carry out strategies health education to work issues inherent in the pregnant-puerperal period. This program is based on the principle that humane care is a precondition for the proper monitoring of partum and postpartum care.

The humanization comprises two basic aspects: the first is the duty to receive with dignity the women, their families and the newborn, which requires ethical attitude and caring professionals and the organization of the institution to create a cozy atmosphere with hospital routines that break the traditional isolation imposed on women. The second is the adoption of beneficial measures for the monitoring of labor and birth, avoiding unnecessary interventions, which although traditionally realysed, do not benefit the woman or the baby and often carry risks to both.⁹

The humanized assistance provides the women with a strong sense of trust and safety during the childbirth, and when taking care of their children have a lot of experience of self-transformation, of being able to play their new social role.¹⁰ To promote humanization of gestate, give birth born and it is necessary to involve all stakeholders in this process, since users, families, professionals, managers, in a line of actions that will promote the health of this woman and her son.

Given the importance of humanization of prenatal care and birth for the woman, her son, her family and society, aroused the interest in developing a reflective study on

the implementation of PHPN public policy in Brazil and the humanization of assistance to women and his son from the perspective of health promotion thereof. Furthermore, this study will contribute to the expansion of knowledge and reflection on the importance of humanization during pregnancy and childbirth by health professionals and managers, contributing to the adoption of actions, strategies and humanized care. Based on these aimed to reflect on health promotion in the context of PHPN.

METHOD

Reflective study that sought to reflect on the promotion of health in the setting of PHPN. Developed as a partial requirement for the evaluation of nursing disciplines and the Health Promotion Theoretical Foundations and Advanced Topics in Health Education Course Master of Nursing, Federal University of Ceara (UFC), processed through the first half of 2011.

For its development was performed the narrative review aimed at gathering knowledge about the topic under study, integrating it and facilitating its accumulation. The literature included articles, manuals of the Ministry of Health of Brazil, relevant legislation and books. Articles were searched in the databases LILACS (Latin American and Caribbean Health Sciences) and BDENF Library (Nursing). We included full text articles, available electronically, published in Portuguese, English or Spanish, since 2000, the year it was created PHPN by 2010.

To search for such articles was used the descriptors controlled "health promotion" and "humanized birth." The search was performed by on-line access in March 2011. After reading and BOOK REPORT of the available literature, we proceeded to descriptive analysis and the same content, which contributed to the debate on the subject.

RESULTS

The results are the reflections resulting from the reading and analysis of the studied material, and best presentation were organized into three topics so entitled, the humanization of childbirth in Brazil; Program for Humanization of Prenatal and Birth, and health promotion and education health in the context of the humanization of labor and birth.

• The humanization of childbirth in Brazil

The concept of humanized care is extensive and involves a set of knowledge, attitudes and

practices aimed at promoting healthy labor and birth and prevention of maternal and perinatal morbidity and mortality. It starts from pre-natal and seeks to ensure that the health staff perform procedures proven beneficial for the woman and the baby, avoiding unnecessary interventions and preserving your privacy and autonomy.¹²

Based on these, the humanized birth is a reflexive movement that aims to rearrange the obstetric procedures of attendance at the birth, which arose mainly by high rates of caesarean sections and dissatisfaction of users with the service, aiming to respect the particularities of women.¹³

Within the perspective of humanized birth, which is opposed to expanding technology, health professionals must assume a facilitating role in this experience, putting the service of well-being of the woman and baby, recognizing the critical moments in which their interventions are necessary for the health of both. So, professionals can minimize the pain through non-pharmacological measures, getting along, comforting, explaining the risks of the adoption of interventionist measures, finally, helping to give birth and come.¹²⁻³

Recognize the individuality is humanizing the care. This attitude allows the professional to establish links with women, see their needs and capabilities to deal with the birth process, and promote relationships less unequal and less authoritarian, in that the professional adopt behaviors that bring well-being and safety for the woman and the baby.¹²

It is worth to mention an innovative humanization developed at the Center for Childbirth Itapecerica da Serra, SP. In those births are performed by nurse-midwives with support focused on the needs of the mother and following the procedures established by the MS to the attention to labor and birth, such as diet and fluid intake during labor free, companion of the woman's choice, freedom to move; adoption of non-pharmacological methods of pain relief, consider the woman's desire, allowing interaction between mother and child, encouraging early breastfeeding among others.¹⁴

A study evaluating the assistance in a Birth Center, the scene of the humanization of birth, found that women seeking this service offered by humanized care, which depends not only on the physical structure or routines and rules enforced, but also of the compromised professional attitude with a sensitive and competent care.¹⁵ Houses of labor have the potential to contribute to the

promotion of humane practices and may also reduce drug and interventionist behavior during childbirth and coming.¹⁶

In an investigation with a qualitative research design, held in a public maternity hospital in Rio de Janeiro, it was found that most respondents do not know the proposal for humanization of childbirth care. The possibility of having a companion was the only innovation that some have cited. That is, no information about different forms of care and more choice, left to those users compliance with the care traditionally offered.¹⁷

So, there are several scenarios in which health professionals can play in promoting humane childbirth, and in recent decades a number of measures have been adopted to guarantee women the right to humanized birth, such as PHPN.

• Humanization Program of Prenatal and Birth-PHPN

The PHPN was established by the Ministry of Health Decree / GM No. 569 of 01.06.2000, in the analysis of subsidized care needs specific to pregnant women, newborn and mother in the postpartum period. Its primary objective to ensure improved access, coverage and quality of prenatal care, childbirth and the postpartum period, pregnant women and newborn, the prospects of the rights of citizenship.⁹

Only in 2000 the term humanization was officially adopted, from the launch of PHPN.⁸ The sense of the term used was the humanization of equity / citizenship: the right to all pregnant women have prenatal care full and complete (minimum of six visits query and puerperium), all recommended tests, the tetanus vaccine and the guarantee of vacancy for labor. In addition to financial incentives to municipalities that qualify your prenatal care and to ensure vacant hospitals for pregnant women enrolled in the program.¹⁸

This program has as its priorities to focus efforts to reduce rates of maternal mortality, perinatal and neonatal adopt measures to improve access, coverage and quality of prenatal care to childbirth, postpartum and neonatal care. Another priority is to expand the actions already taken by MS in the area of care for pregnant women, such as investments in the state system of care for pregnant women at high risk, increasing the cost of specific procedures, and other actions such as the Safe Motherhood Project of training of Traditional Birth Attendants, and the allocation of resources for professional training and investment in the hospital units.⁹

It can be seen that the intentions of the program are broad and complex, involving federal managers, state and local health professionals, civil society and other actors involved in promoting quality and humane care to the woman and her son.

The PHPN presupposes a set of actions and procedures for basic assistance to women during pregnancy and childbirth and the newborn, integrating three main components: Component I-Incentives to prenatal care (in the registration of pregnant women in Sis prenatal at the conclusion of prenatal care and childbirth); Component II-Organization, regulation and investment in obstetric and neonatal and Component III-New system for payment of assistance to birth.⁹

Each of these components requires integrated action between the three levels of management, with coordination between the MS and the Departments of Health for the evaluation of the program are used as indicators calculated by Sis prenatal, which act as parameters to evaluate compliance with the assumptions of PHPN by municipalities that joined to the same.

When experiencing high rates of maternal and perinatal mortality, low coverage of prenatal care, or media reports of women wandering in a quest to find a place to give birth or stories of women who have not successfully finish this pilgrimage and giving birth in ambulances sidewalks or in hospitals, it is clear the need for reflection on the implementation of PHPN. This program, in its ten years of existence, proposes to give a humanized childbirth and birth that goes against these reports of violence and dehumanization of women, their fetus and family.

From this perspective PHPN assessment, studies of MS and other researchers, mentioned below, have evaluated their impact on improving care for pregnancy and childbirth, and investigated whether indicators of states and municipalities are in agreement with the recommendations by the program.

A study conducted by the Ministry assessed the PHPN and found that in 2002 the 5,561 Brazilian municipalities, 3,923 had joined the program. Of these, 2031 had some record of producing the program and only 634 had a record in Sis prenatal. And showed the following considerations: the achievement of the procedures are more common in big cities and the time of joining the program is inversely proportional to the size of the municipality; adherence to the Family Health Strategy (FHS) was not associated to the accession or not to PHPN, offering services in

the municipalities facilitates the implementation of the program, the highest dropout rates to prenatal happen in the capital and the best indicators of prenatal care are in the South and Southeast.¹⁹

Furthermore, they found themselves as weaknesses of PHPN the lack of integration between prenatal care and childbirth; reduced realization of exams in the 3rd trimester of pregnancy; sparse realization of puerperal consultation, the guidelines for humanization has not been fulfilled, for visits of pregnant women to hospitals, recommended by the program, do not occur. Another weakness is that the analysis of Sis prenatal indicates that the system is accessible, consistent, has the potential to instrumentalize the management PHPN by issuing reports, but not comprehensively portray the reality of service performed and presents gap in time and quantity of data available from the local system when compared to the central level.¹⁹

When one reflects on this assessment PHPN, we find an emphasis on the analysis of indicators of operation of the prenatal time of joining the program, implementation of recommended procedures, system analysis Sis prenatal, among others. Having a single moment that reports the humanization, where it is stated that the visits of pregnant women to hospitals used as reference did not occur. It is noticed that the reflection on the humanization was promptly placed in the document requiring magnification.

Such study of MS also carried out an assessment of qualitative data in seven municipalities from semi-structured interviews with professionals and focus groups with users of health services. This research found that there is a dissonance between many of these recommendations and the wishes and needs of women, which causes it to draw you another stream of care. Harm the relationship that it establishes with the service, besides the difficulty of controlling the real follow-up which is being offered.²⁰

The evaluation of data from 720,871 women enrolled in SISPRENATAL between 2001 and 2002 found a significant increase of PHPN with 9.25% and 27.92% of pregnant women enrolled in these two years respectively, of which 90% were registered within 120 days of gestation. Only 2% of the pregnant women in 2001 and 5% in 2002 performed the set of care activities recommended by the PHPN. This indicates that as you add criteria recommended by the health care program, the percentage of coverage decreases, inferring that the implementation of all

activities is the biggest challenge in primary pre-natal.²¹

A study conducted in the state of Ceara, which evaluated the PHPN indicators from 2001 to 2006, totaling the evaluation of data from 312,507 pregnant women enrolled in the program, found that

the percentage of pregnant women registered has increased each year, up from 9.11% in 2001 to 64.17% in 2006. When associated assessment indicators of prenatal care (minimum of six prenatal consultations, puerperal consultation, laboratory tests, tetanus immunization, HIV testing) is the indicator with the lowest percentage with an average of 15.67% of women having the right to this set of procedures.²² This goes against the recommendations PHPN by interfering with the quality and the humanization of prenatal care offered.

Research conducted in Rio Grande, Rio Grande do Sul, with 2,557 mothers in 2007, assessed the coverage of prenatal care according to family income, concluded that the health service was not very effective, since only 26.8% of prenatal were appropriate according to PHPN. And the service ranked as unequal, because the users with lower income had prenatal care with quality below the best income.²³

As we consider these evaluative studies of PHPN, we find a predominance of studies of indicators of prenatal coverage and minimum procedures specified by the program. It appears that, despite the improvement of these indicators after the implementation of the program, women are being deprived of basic steps that should be present for the right to health of the woman and her son was fully assured.

• Health promotion and health education in the context of humanization of prenatal care and birth

As provided by Law 8080²⁴, assistance to people from the promotion, protection and recovery of Health-achieving integrated care actions and preventive activities are goals of the Unified Health System (SUS).

It is understood by health promotion, the process of enabling people to increase their control over the determinants of health, promoting an improvement in their quality of life and health.²⁵

Health education is a key element of health promotion, being a form of care that enables the development of critical and reflective awareness and empowerment of individuals to promote the production of knowledge that helps people to take better care of

themselves and their relatives.²⁶ This is consistent with the assumptions of Paulo Freire²⁷, which argues that teaching is not to transfer knowledge but to create the possibilities for your production or construction.

Based on these, health education and health promotion become intimately related, since the latter depends upon the active participation of the population well informed in the process of change. The promotion is associated with the role of individuals as citizens with rights that must be respected and they need to have guarded their autonomy. Education as a tool for health promotion and encouragement to self-care in prenatal care, as recommended by PHPN, corroborates with this perspective of empowerment of individuals' health-disease process.

The National Policy of Humanization NPH-MS conceptualizes humanization as valuing individuals involved in the process of health production (users, workers, managers), emphasizing the autonomy of the people and leadership, shared responsibility, among them the establishing solidarity bonds and collective participation in the management process.²⁸

The proposed project of humanization of society based on equity, in which access to health services humanized and quality reflects the guarantee of citizenship in a society democratic. This proposal points out to the necessity of a new paradigm in health care, guided in humanization, health promotion, empowerment of the population and ethical behavior in interpersonal relations that values differences and identities of individuals, recognizing them as citizens with rights, worthy host and comprehension.²⁹

The promotion of women's health and their children implies the humanization of the whole process of gestate, give birth and to be born, so that should not talk about health promotion, without humanization. A qualified and humanized occurs by means of pipes warm and without unnecessary interventions, access to quality services and health promotion, prevention and health care to pregnant women and newborn.³⁰

The PHPN contributes to the promotion of mother and child health, as it brings preconization for the attention to quality, seeking to guarantee the right to a process gestate, give birth and be born healthy. The implicit humanization in the program confirms the autonomy of pregnant women in the act of giving birth, an experience that is part of

human nature and must be lived with freedom by the woman and her family.

FINAL CONSIDERATIONS

Health promotion that permeates the PHPN contemplates a guarantee of quality care to the mother and fetus and humanization guaranteeing women a starring role in an event inherent in their life cycle and in which their autonomy must be guaranteed through legislation and public policy implemented by the MOH and implemented by the federal government, state and municipal governments at all levels of health care.

However, despite the relevance of humanization during pregnancy and childbirth are still dehumanizing practices that violate the rights of the woman and her fetus, which can be related to lack of knowledge and information about the rights gained by women in the process parturition, causing them to undergo the procedures of health professionals, no questions or choices. To improve this scenario, it is necessary to empower these women through health education strategies, in order to ensure their free information and their decision making. Autonomy in pregnancy and childbirth is fundamental to the promotion of a humanized care, which is recommended by public health policies, as PHPN.

It is noteworthy that in reflecting on the evaluation of PHPN, there is a predominance of quantitative analysis, ie, the number of prenatal consultations, implementation of immunization against tetanus, among other procedures recommended. Since the evaluation of humanization is verified in a prompt form. It is necessary to perform other studies that discuss and investigate the analysis of the humanization of the mother and child.

Soon, nurses and all health care team who works in labor and birth PHPN need to know and reflect on it as a policy that allows the promotion of women's health and his son, contributing to a humane and quality care as a right of citizenship.

REFERENCES

1. Stevens CMT. Maternidade e literatura: desconstruindo mitos. In: Swain TN, Muniz DCG, organizadores. Mulheres em ação: práticas discursivas, práticas políticas. Florianópolis (SC): Editora Mulheres/Belo Horizonte (MG): PUC-Minas; 2005. p. 35-72.
2. Diniz CSG. Humanização da assistência ao parto no Brasil: os muitos sentidos de um movimento. Cien Saude Colet. 2005 [cited

2012 May 08]; 10(3):627-37. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S141381232005000300019&lng=en&nrm=is.

3. Castro JC, Clapis MJ. Parto humanizado na percepção das enfermeiras obstétricas envolvidas com a assistência ao parto. Rev Latino-Am Enfermagem [Internet]. 2005 Dec [cited 2011 Apr 18]; 13(6):960-7. Available from:

http://www.scielo.br/scielo.php?script=sci_arttext&pid=S010411692005000600007&lng=en. doi: 10.1590/S0104-11692005000600007

4. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Pré-natal e puerpério: atenção qualificada e humanizada. Brasília (DF): MS; 2005.

5. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Manual dos Comitês de Mortalidade Materna. Brasília (DF): MS; 2007.

6. Ministério da Saúde (BR), Manual de Vigilância do Óbito Infantil e Fetal e do Comitê de Prevenção do Óbito Infantil e Fetal. Brasília (DF): MS; 2009.

7. Lansky S, França E, Perpétuo IH, Ishitane I. A mortalidade Infantil: tendências da mortalidade neonatal e pós-neonatal em 20 anos do SUS. Brasília (DF): MS; 2009.

8. Ministério da Saúde (BR), Portaria GM/MS n. 568, de 01 de junho de 2000. Institui o Programa de Humanização no Pré-natal e Nascimento no âmbito do Sistema único de Saúde. Diário Oficial da União, Brasília, DF. 2000 Aug 18. p.112.

9. Ministério da Saúde (BR), Programa Humanização do parto: humanização no pré-natal e nascimento. Brasília (DF): MS; 2002.

10. Silva LM, Barbieri M, Fustinoni SM. Vivenciando a experiência da parturição em um modelo assistencial humanizado. Rev bras enferm [Internet]. 2011 Feb [cited 2011 Apr 17]; 64(1):60-5. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S003471672011000100009&lng=en.

11. Polit DF, Beck, CT. Fundamentos de pesquisa em enfermagem: avaliação de evidências para a prática de enfermagem. Porto Alegre (RS): Artmed; 2011.

12. Ministério da Saúde (BR)/Febrasgo/Abenfo. Parto, aborto e puerpério: assistência humanizada à mulher. Brasília (DF): MS; 2001.

13. Nagahama EEI, Santiago SM. Práticas de atenção ao parto e os desafios para humanização do cuidado em dois hospitais

vinculados ao Sistema Único de Saúde em município da Região Sul do Brasil. Cad. Saúde Pública [Internet]. 2008 Aug [cited 2011 May 13]; 24(8):1859-68. Available from: http://www.scielo.org/scielo.php?script=sci_arttext&pid=S0102311X2008000800014&lng=en. doi: 10.1590/S0102-311X2008000800014.

14. Machado NXS, Praça NS. Centro de parto normal e assistência obstétrica centrada nas necessidades da parturiente. Rev Esc Enferm USP [Internet]. 2006 [cited 2012 May 08]; 40(2):274. Available from: http://www.ee.usp.br/reeusp/upload/pdf/24_9.pdf

15. Gonçalves R, Aguiar CA, Merighi MAB, Jesus MCP. Vivenciando o cuidado no contexto de uma casa de parto: o olhar das usuárias. Rev Esc Enferm USP [Internet]. 2011 Mar [cited 2012 May 08]; 45(1):62-70. Available: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-62342011000100009&lng=en. doi: 10.1590/S0080-62342011000100009.

16. Barros WLL, Costa E, Boeckmam LMM, Reis PED, Ponce de Leon CGRM. Humanizing delivery: a reality in a birth center? Rev enferm UFPE on line [Internet]. 2011 Jan/Fev [cited 2012 Mar 4]; 5(1):67-74. Disponível em: <http://www.ufpe.br/revistaenfermagem/index.php/revista/article/view/1207>

17. Dias MAB, Deslandes SF. Expectativas sobre a assistência ao parto de mulheres usuárias de uma maternidade pública do Rio de Janeiro, Brasil: os desafios de uma política pública de humanização da assistência. Cad Saude Publica [Internet]. 2006 Dec [cited 2011 May 30]; 22(12):2647-55. Available from: http://www.scielo.org/scielo.php?script=sci_arttext&pid=S0102311X2006001200014&lng=pt. doi: 10.1590/S0102-311X2006001200014.

18. Rattner D. Humanização na atenção a nascimentos e partos: breve referencial teórico. Interface [Internet]. 2009 [cited 2012 May 08]; 13(supl1):595-602. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-32832009000500011&lng=en. doi: 10.1590/S1414-32832009000500011

19. Ministério da Saúde (BR). Avaliação Nacional do Programa de Humanização do Pré-natal e Nascimento. Rev Saude Publica [Internet]. 2008 Apr [cited 2012 May 08]; 42(2):383-7. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102008000200029&lng=en. doi: 10.1590/S0034-89102008000200029.

20. Almeida CAL, Tanaka OY. Perspectivas das mulheres na avaliação do Programa de Humanização do Pré-natal e Nascimento. Rev Saude Publica [Internet]. 2009 Fev [cited 2012 May 08]; 43(1):98-104. Available:

http://www.scielo.br/scielo.php?script=sci_ar_ttext&pid=S0034-89102009000100013&lng=pt. doi: 10.1590/S0034-89102009000100013.

21. Serruya SJ, Cecatti JG, Lago TG. O Programa de Humanização no Pré-natal e Nascimento do Ministério da Saúde no Brasil: resultados. Cad Saude Publica [Internet]. 2004 Oct [cited 2012 May 08]; 20(5):1281-89. Available from: http://www.scielo.br/scielo.php?script=sci_ar_ttext&pid=S0102-311X2004000500022&lng=pt. doi: 10.1590/S0102-311X2004000500022.

22. Passos AA, Moura ERF. Process indicators in the program for Humanization of Prenatal Care and Childbirth in Ceará State, Brazil: analysis of a historical series (2001-2006). Cad Saude Publica [Internet]. 2008 Jul [cited 2012 May 08]; 24(7):1572-80. Available from: http://www.scielo.br/scielo.php?script=sci_ar_ttext&pid=S0102-311X2008000700012&lng=pt. doi: 10.1590/S0102-311X2008000700012

23. Gonçalves CV, Cesar JA, Mendoz-Sassi RA. Qualidade e equidade na assistência à gestante: um estudo de base populacional. Cad Saude Publica [Internet]. 2009 Nov [cited 2012 May 08]; 25(11):2507-16. Available from: http://www.scielo.br/scielo.php?script=sci_ar_ttext&pid=S0102-311X2009001100020&lng=en. doi: 10.1590/S0102-311X2009001100020.

24. Ministério da saúde (BR), Lei n. 8.080, 19 de setembro de 1990. Presidência da República. Subchefia para assuntos jurídicos. Brasília: Diário Oficial da República Federativa do Brasil, 1990.

25. Arbo RC, Bianchi D. Programa: Grupo de Gestantes Gravidez Saudável, Parto Humanizado. Secretaria Municipal de Saúde. Prefeitura Municipal de Bom Progresso; 2009.

26. Santos RV, Penna CMM. A educação em saúde como estratégia para o cuidado à gestante, puérpera e ao recém-nascido. Texto contexto-enferm [Internet]. 2009 Dec [cited 2012 May 08]; 18(4): 652-60. Available from: http://www.scielo.br/scielo.php?script=sci_ar_ttext&pid=S0104-07072009000400006&lng=en. doi: 10.1590/S0104-07072009000400006.

27. Freire, P. Pedagogia da autonomia: saberes necessários à prática educativa. São Paulo (SP): Paz e Terra; 2008.

28. Ministério da Saúde (BR). Humaniza SUS: Política Nacional de Humanização. Brasília (DF): MS; 2004.

29. Zampieri MFM, Erdmann AL. Cuidado Humanizado no pré-natal: um olhar para além das divergências e convergências. Rev Bras Saúde Matern Infant. 2010 July-Sept; 10(3): 359-67.

30. Ministério da Saúde (BR). Manual Técnico Pré-Natal e Puerpério: atenção qualificada e humanizada. Brasília (DF): MS; 2006.

Sources of funding: No

Conflict of interest: No

Date of first submission: 2012/04/03

Last received: 2012/05/05

Accepted: 2012/05/06

Publishing: 2012/07/01

Corresponding Address

Linicarla Fabiole de Souza Gomes

Rua Uirapuru, 957 (casa) – Maraponga

CEP: 60711-790 – Fortaleza (CE), Brazil