

DELIVERY PLAN IN CONVERSATION CIRCLES: WOMEN'S CHOICES

PLANO DE PARTO EM RODAS DE CONVERSA: ESCOLHAS DAS MULHERES

EL PLAN DE PARTO EN RUEDAS DE CONVERSACIÓN: OPCIONES DE LA MUJER

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Submitted on: 2017/04/22

Approved on: 2017/07/28

ABSTRACT

The objective was to characterize the desires and expectations of pregnant women described in a delivery plan. This is an exploratory descriptive study using the delivery plan of the pregnant woman's handbook of the Municipal Health Department of Belo Horizonte as instrument. The study included 84 pregnant women in prenatal care, from March to November 2014. The results showed that 71 out of 84 women indicated the husband as chosen companion, 68 would like to use the shower/bath to relieve the pain, and 23 mentioned the use of anesthesia. Thus, it was possible to learn the main choices regarding the parturitive process. It is up to health professionals to provide information to contribute to women's decision-making. We believe that, by acquiring knowledge and receiving encouragement from the health team, pregnant women will make informed choices and the care will be closer to the qualified and humanized model.

Keywords: Decision Making; Patient Participation; Humanizing Delivery; Obstetric Nursing.

RESUMO

Objetivou-se caracterizar os desejos e expectativas de gestantes descritos em um plano de parto. Estudo descritivo exploratório, tendo como instrumento o plano de parto da caderneta da gestante da Secretaria Municipal de Saúde de Belo Horizonte. Fizeram parte do estudo 84 gestantes em acompanhamento pré-natal, no período de março a novembro de 2014. Os resultados evidenciaram que, das 84 mulheres, 71 indicaram o marido como acompanhante de sua escolha, 68 gostariam de fazer uso do banho de chuveiro/banheira para aliviar as dores, enquanto 23 referiram o uso de anestesia. Assim, foi possível conhecer as principais escolhas relativas ao processo parturitivo. Cabe aos profissionais de saúde proporcionar informações que contribuam para a tomada de decisão da mulher. Acredita-se que, ao adquirir conhecimento e receber estímulo da equipe de saúde, a gestante realizará escolhas informadas e se aproximará de um atendimento qualificado e humanizado.

Palavras-chave: Tomada de Decisões; Participação do Paciente; Parto Humanizado; Enfermagem Obstétrica.

RESUMEN

El objetivo del presente estudio fue definir los deseos y expectativas de las embarazadas descritos en un plan de parto. Estudio descriptivo exploratorio cuyo instrumento era el plan de parto de la libreta de la embarazada de la Secretaría Municipal de Salud de Belo Horizonte. Participaron 84 gestantes en seguimiento prenatal, entre marzo y noviembre de 2014. Los resultados evidenciaron que, de las 84 mujeres, 71 eligieron a su marido como acompañante, 68 querían usar la ducha o la bañera para aliviar el dolor y 23 se refirieron a la anestesia. De este modo, pudieron conocerse las principales opciones para el proceso de parto. Les corresponde a los profesionales de la salud brindar información que contribuya a la toma de decisiones de la mujer. Se entiende que al adquirir conocimiento y recibir estímulo del equipo de salud, la mujer embarazada realizará elecciones informadas y tendrá más posibilidades de recibir atención calificada y humanizada.

Palabras clave: Toma de Decisiones; Participación Del Paciente; Parto Humanizado; Enfermería Obstétrica.

How to cite this article:

Gomes RPC, Silva RS, Oliveira DCC, Manzo BF, Guimarães GL, Souza KV. Delivery plan in conversation circles: women's choices. REME – Rev Min Enferm. 2017[cited _____];21:e-1033. Available from: _____ DOI: 10.5935/1415-2762.20170043

INTRODUCTION

Over the years, the history of the parturition process has been progressively changing. At first, births would happen in a familiar and intimate environment, allowing women to express themselves, being assisted exclusively by women called midwives. With the advent of technology and new discoveries in the scientific field aimed at controlling complications and possible risks, childbirth is no longer carried out in private spaces, but in a new environment: the hospital.^{1,2}

Labor and childbirth are now assisted by a technocratic model of attention. Such a model is discussed by Davis-Floyd as being based on the figure of the doctor, who deals with pregnancy as if it was a disease and uses innumerable, and often unnecessary, interventions and medications.³ Thus, the place, the type of birth, the moment of delivery, the companion, among other preferences, began to be defined by the professionals, depriving women of the power of decision over their own body and choices.⁴

As a consequence, health indicators reflect the poor quality of obstetric care in Brazil, with high rates of maternal and perinatal morbidity and mortality, as well as of cesarean sections.⁵ This context of risks to the mother-child binomial and dissatisfaction with the assistance offered to women gave boost to social movements in favor of women's sexual and reproductive rights began in the 1980s and 1990s, to guarantee access to integral health and to rescue the autonomy and dignity of women, as well as the humanization in the process of parturition.^{6,7}

In order to encourage the improvement of this assistance and stimulate the use of practices based on scientific evidence, the Ministry of Health (MOH) has implemented a set of actions through Decrees aimed at the discontinuation of unnecessary practices such as the routine episiotomy, enema, use of forceps and excessive cesarean surgeries.⁶

A manual of the National Program for Humanization of Hospital Care (NPHHC) was published in 2002 with the aim of promoting humanized practices in hospital services and satisfying and encouraging women to actively participate in the decisions taken, including the position to give birth, the companion, and others. These are recognized as good practices in childbirth and delivery care and have been recommended by the World Health Organization (WHO) since 1996.⁸

Among the good practices, there is the delivery plan (DP). This is a written document in which the pregnant women express in advance their choices regarding the care they would like to receive during labor and delivery, avoiding unnecessary and unwanted interventions.⁹ The filling should preferably be performed after the woman receives clarification about the gestation, the physiology of the delivery, the possibility of her making choices, the valuation of normal delivery, the risks of unnecessary interventions, such as scheduled cesarean surgery, among other information.¹⁰ The informed choice promotes the

active participation of women in the parturition process and expresses a right that must be exercised by them and guided by health professionals.¹⁰

The delivery plan must be passed on to the professionals at the moment the pregnant woman enters the maternity ward, making possible that decisions be shared between all involved in the assistance to the childbirth and to the woman.¹¹ In view of the various strategies practiced with the purpose of rescuing the delivery as an empowering process of women and, thus, eliminating the interventionist culture, health professionals play a relevant role in the effectuation of the woman's delivery plan. If the team ignores the plan, the autonomy and the choices of the woman will be surrendered to the will of these professionals, who come to occupy the protagonist role that is supposed to be of the parturient, while the woman is transferred to the supporting role.

Based on the possibility that women are given of reflecting on their preferences and expressing them in a birth plan, the question is: what are their choices regarding the labor and birth process? In view of the above, this article intends to characterize the desires and expectations of pregnant women expressed in the delivery plan. The relevance of the present study is in the possibility to guide the care team about what women want.

The nursing team closely follows pregnant women throughout the parturition process and, therefore, has the duty of sharing with other professionals involved the wishes expressed in the delivery plan, as well as of offering a qualified care to meet the expectations and allow women to exercise their autonomy grounded on informed choices.

METHOD

This is a descriptive-exploratory study with quantitative approach, using part of a research entitled "Building strategies for strengthening and rescuing the autonomy of women in the process of delivery and birth".

The study was developed by means of conversation circles with pregnant women enrolled in the prenatal system (SIS Prenatal), in 21 basic health units (BHU) of the districts of the North region and the Venda Nova region of the city of Belo Horizonte. The districts were selected considering the link of the BHUs with the Unified Health System (SUS) maternity hospitals that met the NPHHC humanization proposals.

The conversation circles took place at the BHU after a wide dissemination for four weeks, through posters, direct contact with pregnant women in waiting rooms, health professionals and community health agents (CHA). They were carried out with dates and times previously determined with the managers of the basic units.

A sample of 114 pregnant women participated in the study. The inclusion criteria were pregnant with any gestational age and

enrolled in the prenatal care of the BHU. However, the exclusion criteria were pregnant with difficulty or impossibility of verbal communication, with mental difficulties and non-attendance to the conversation circles. Eight out of the 114 pregnant women did not complete their participation, often because they had a medical appointment at the same time of the conversation circle, reducing the sample to 106 women. However, among these 106, 22 did not meet the proposal of complete filling of the delivery plan, accounting for a final sample of 84 pregnant women for this study.

Thirty-two conversation circles were carried out from March to November 2014, conducted by trained researchers and members of the project and with the involvement of service professionals. It is worth mentioning that, in some units, there was more than one conversation circle, including always different participants in order to meet the local demand.

The purpose of the conversations was to inform pregnant women about the delivery plan and motivate them to use this tool, elucidating their perceptions and needs regarding the delivery and birth process and exploring their expectations regarding care, labor, delivery and postpartum.

At the end of the conversation, the pregnant women had the opportunity to prepare their delivery plan using as a model what is included in the pregnant woman's handbook (Table 1) of the Municipal Health Department of Belo Horizonte (SMSA-BH). They were also encouraged to identify items they would like to include in their plan and were not in the proposed delivery plan. In the proposed plan, women could make more than one choice in each question.

Thus, there was an opportunity to discuss the preferences registered by the pregnant women in their plans, clarifying:

the scientific bases that underlie these preferences, as well as their benefits and their implications for them, for their newborns and their families; the relationship between their choices and institutional and professional practices (limits, possibilities); and, finally, the exchange of experience in drawing up the plan. The plan was completed in two copies and one of them was delivered by the participants to the researchers.

A database was prepared in an electronic spreadsheet for descriptive analysis procedures. The sample was characterized with the distribution of absolute and relative frequencies of the variables of interest according to the choices of the women. The results were organized in chronological order of delivery.

The project was evaluated and approved by the Research Ethics Committee of the Federal University of Minas Gerais COEP/EEUFMG under CAAE nº 12186813.9.1001.5149 and by the SMSA-BH and financed by the Research Support Foundation of Minas Gerais (FAPEMIG) under Opinion nº 508.446. The research obeyed the ethical aspects of research involving human beings, according to Resolution 466/12 NCH/MOH. All participants and their guardians, when they were under 18 years of age, signed an informed consent form (IC) after receiving explanation of the purpose and details of the study.

RESULTS

Eighty-four out of the total number of participants in the conversation responded to the invitation to fill out the delivery plan (Table 2). Of these, 84.52% wished to be accompanied during hospitalization by their husband/partner/father of the newborn – (NB).

Table 1 - SMSA-BH Delivery Plan Template(*)

In order to meet your needs at childbirth, it is essential to register your wishes and expectations beforehand. The delivery process should begin when the contractions become regular and the cervix becomes thin and dilated. In case of fluid or blood loss, even without contractions, the woman should seek the health service. You can have the companion you want.

1- Companions you want during maternity stay:

<input type="checkbox"/> Husband/partner/father of the NB	<input type="checkbox"/> Mother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Friends
<input type="checkbox"/> Other relatives	<input type="checkbox"/> Doula	<input type="checkbox"/> None	<input type="checkbox"/> Others: _____

In labor, it is recommended that the woman move freely. The position lying on your back should be avoided. Shaving is unnecessary, as well as intestinal lavage. If you wish, you can request a suppository of glycerin to empty the intestine, avoiding exits of feces at the time of delivery.

2- Do you want to use glycerin suppository?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Several techniques can be used to relieve pain during labor. You can still choose to use pain relieving medicines. In this case, the anesthetist will inject them into a space near the spine.

3- Methods for pain relief that you want to have as an option:

<input type="checkbox"/> Massages	<input type="checkbox"/> Deep breathing	<input type="checkbox"/> Relaxing exercises with birth ball	<input type="checkbox"/> Bath or shower
<input type="checkbox"/> Anesthesia with medicines	<input type="checkbox"/> Others: _____		

Continue...

... continued

Table 1 - SMSA-BH Delivery Plan Template(*)

You can also take fluids to stay hydrated.			
4- Liquids you want to ingest:			
<input type="checkbox"/> Fruit juice	<input type="checkbox"/> Teas	<input type="checkbox"/> Gelatin	<input type="checkbox"/> Others: _____
5- Keeping the environment dim and music can help relax and reassure you.			
<input type="checkbox"/> Do you want a low-light environment during labor or delivery?		<input type="checkbox"/> Do you want to listen to music during labor or delivery?	
6- In which position do you want to give birth?			
<input type="checkbox"/> Sitting/Squatting	<input type="checkbox"/> Lying with raised headboard	<input type="checkbox"/> Sideways	<input type="checkbox"/> Others: _____
In a few cases it may be necessary to cut the vagina. If necessary, you must be informed by the professional and give your consent.			
The NB that is born is properly dried and kept in skin-to-skin contact with the mother, before even cutting the cord. This should only be cut after stopping pulsing (after one minute of life). The newborn should be placed to nurse as soon as born and should stay with the mother throughout the hospital stay.			
7- As for umbilical cord cutting, you prefer it to be done:			
<input type="checkbox"/> By the professional	<input type="checkbox"/> By yourself	<input type="checkbox"/> By the husband/partner/father of the NB	<input type="checkbox"/> Others: _____
After delivery, vitamin K is administered to the muscle of the infant's leg to prevent bleeding, and eye drops are dripped to avoid infection. You should avoid bathing the baby in the first few hours so that the NB does not cool down. The umbilical stump dressing is made with alcohol. If the mother is well, she can bathe and feed herself with any food she wants. Professionals periodically evaluate bleeding after delivery and help with breastfeeding.			
8- If you have other wishes and expectations regarding the experience of childbirth, register here:			

(*) Source: Municipal Health Department of Belo Horizonte. Mother-to-child health: care for mother and child from prenatal care towards a healthy pregnancy, delivery and birth.

Regarding the liquids they wished to ingest during labor, more than half of the women, 63.10%, opted for fruit juice, while 38.10% chose gelatine, 14.29% preferred tea and 22.62% selected others types of liquids, including water.

About the environment of labor and delivery, 70.24% preferred little light. In this item, 29.76% did not express this preference, and 40.48% wished to listen to music.

As for non-pharmacological methods for pain relief, 80.95% of the pregnant women would like to use the shower/bath, 58.33% would like to receive massages, 45.24% would perform deep breathing, and 45.24% would exercise relaxation with the birth ball and with the bench; in these issue, pregnant women could choose more than one option. As a pharmacological method, local analgesia was chosen by 27.38% of the parturients.

For the moment of delivery, the use of the glycerin suppository was desired by 48.81% of the pregnant women. The position lying with the headboard raised was chosen by 51.19% of the parturients, while 44.05% chose to give birth

seated or squatting, and 8.33% chose other positions, and 4.76% chose sideways.

Regarding the umbilical cord cutting, 51.19% chose that this should be performed by the husband/partner/father of the newborn, while 46.43% by the professional, and only 2.38% by themselves.

DISCUSSION

When it comes to the presence of the companion, all the women expressed the desire to be accompanied during their labor and delivery. Law 11,108, regulated by the Ordinance of the Ministry of Health nº 2418, in 2005, guarantees the presence and the involvement of an accompanying person during the whole period of labor, delivery and immediate postpartum, which consists of up to 10 days after delivery. This companion should be chosen by the parturient.¹² In the present study, most of the participants had a preference for the presence of their husband/partner/father of the NB.

Table 2 - Choices of pregnant women expressed in the delivery plan in Belo Horizonte, in the Norte and Venda Nova regions – 2014

	Variables	N	%
Companion in the maternity ward	Husband/partner/father of the NB	71	84.52%
	Mother	22	26.19%
	Daughter/son	3	3.57%
	Friends	2	2.38%
	Other relative	11	13.10%
	Doula	3	3.57%
Liquids you want to ingest	Juice	53	63.10%
	Gelatin	32	38.10%
	Tea	12	14.29%
	Others	19	22.62%
	Environment	Low light	59
	With music	34	40.48%
Methods for pain relief	Massage	49	58.33%
	Deep breathing	38	45.24%
	Ball relaxation exercises	38	45.24%
	Bath or shower	68	80.95%
	Pharmacological anesthesia	23	27.38%
Suppository use	Yes	41	48.81%
	No	39	46.43%
Positions for delivery	Lying with raised headboard	43	51.19%
	Sitting/Squatting	37	44.05%
	Others	7	8.33%
	Sideways	4	4.76%
Umbilical cord cutting	Husband/partner/father of the NB	43	51.19%
	Professional	39	46.43%
	Others	5	5.95%
	Yourself	2	2.38%

Source: prepared for purposes of this research.

Note: The pregnant women could choose more than one option in the questions of the delivery plan, totalizing an n of more than 100%.

Such practice, besides being a right guaranteed by the law, is classified by the MOH as a proven useful practice, based on scientific evidence, and that should be encouraged. Studies report that in this vulnerable period for women, the presence of a family member make them feel more secure, satisfied and happy. It is important to emphasize that the health team, particularly nurses, plays a relevant role in guiding the caregiver about the importance of their active participation during the parturition process, in order to provide the necessary support at that time.^{12,13}

Fasting during labor is classified by the MOH as a frequently used inadequate practice. Because it belongs to an obstetric and anesthetic tradition, this practice is justified by the risk of aspiration of gastric contents during a possible anesthet-

ic procedure. This practice is, therefore, supported on the claim to reduce maternal morbidity and mortality rates.^{8,14}

In contrast, the provision of liquids and light foods during labor is considered an act of respect for the autonomy of women. It is in fact recommended by the Stork Network, because the parturient needs to remain hydrated and with an adequate caloric intake in order to facilitate the parturition process. There is evidence that water and food restriction does not ensure few stomach volumes during anesthesia, thus not minimizing risks to the patient.^{8,14}

Among the delivery plans, in relation to hydration, fruit juice stood out as the most preferred, followed by gelatin and tea. Although water was not an alternative of the proposed plan, many pregnant women expressed the desire to ingest this liquid during labor, suggesting its inclusion in the options.

One of the results of the research was that most women preferred a low-light environment at the moment of delivery. Studies show that extremely bright and noisy environments can have a negative influence on the physiological process of childbirth, due to the stress and tension it generates, which in turn inhibit the release of endogenous oxytocin, delaying uterine contractions and thus prolonging labor.¹⁵

In order for the birth to have its course unchanged, it is necessary to adapt the environment in which it will take place, providing silence, comfort and privacy to the woman. In the hospital context, this adaptation is the responsibility of the team involved in this process, to promote well-being.¹⁵

According to the National Guideline on Assistance to Normal Delivery, launched in 2016, the presence of music in the environment is one of the strategies to relieve pain during labor. Health professionals should support this strategy, provided the songs are chosen by the woman. It is valid to clarify that there is still no satisfactory evidence to conclude about the beneficial effect of music on pain complaints. Even so, in our study, most women planned to listen to their music selection during labor.¹⁴

The management of pain during labor aims to increase the parturient's threshold for tolerance to the painful sensations typical of this clinical period, allowing a positive experience regarding delivery.¹⁴ Thus, non-pharmacological strategies and methods of pain relief should be guaranteed as part of a model of assistance committed to the humanization of care.¹⁶ In this study, the most cited method by the participants was the shower or bath; and then massages. The latter, when performed by the companion, provides relief and promotes complicity. The use of the ball and the deep breathing obtained the same percentage of preference: the ball helps in the descent and fit of the fetus in the pelvis, while deep breathing distracts the attention of the pain.⁸

Another alternative for pain relief is pharmacological methods. This was the option selected by less than half of pregnant women. From the perspective of the humanization of care, analgesia should be administered if the woman requests it, with the

intention of alleviating her pain. However, analgesia has negative implications for women, such as nausea, numbness and dizziness. There are also effects for the newborn, such as respiratory depression at birth and persistent drowsiness. Moreover, the use of analgesia may prolong the expulsive period at delivery, due to several changes in the woman's body, such as relaxation of pelvic floor muscles of the abdominal wall.^{8,14}

The choice of glycerin suppository prevailed among almost half of the pregnant women investigated. However, the MOH and the WHO consider the routine use of enema as a clearly harmful or ineffective practice and should be eliminated from practices performed during childbirth, restricting its use to situations when woman request it.¹⁷ The justification for the use of enteroclysis is based on the belief that this method has benefits such as acceleration of labor and reduction of contamination of the perineal region, resulting in lower maternal and neonatal infection rates. However, its use can generate discomfort and embarrassment to the parturient woman, besides not eliminating the risk of contamination of the perineum with liquid stools.¹⁴ In fact, a systematic review conducted in 2013 including data from several countries and a sample of 1,917 women confirmed that enema does not have a significant effect on infection rates and, therefore, should be discouraged.¹⁸

More than half of the pregnant women chose the position lying down with the headboard raised for the time of delivery. With hospitalization, the supine position and the prohibition of movements throughout the parturition process have been standardized with the justification that, if the pregnant woman remained in left lateral decubitus, there would be an increase in placental perfusion, implying more fetal oxygenation.¹⁴ However, there is evidence that the horizontal position impairs maternal breathing, whereas the vertical position assists gravity, reduces the force applied by the woman when compared to the horizontal position, and minimizes the compression of large vessels. This contributes to the maternal and fetal circulation and extends the passage of the birth canal.⁸ Articles also highlight that women who adopt the vertical position consider it beneficial for providing more comfort, favoring their movement and reducing the expulsive effort.¹⁶

Although the evidence does not show benefits, the supine position was the most frequently preferred in the birthing plans. This happened because this position is still culturally considered the most appropriate by women and some health professionals, since in Brazil more than 90% of women still choose to give birth in that position. Nevertheless, research studies have indicated that national health institutions offer other possibilities for positions to give birth. This is strengthened when nurse-obstetricians are present, because they are professionals committed to the principles of humanization.¹⁶

Among the participants of this study, more than half wanted their partner to cut the umbilical cord after delivery. A quali-

tative study carried out in the municipality of Belo Horizonte, in 2009, reveals that, besides promoting active participation at birth, a stronger emotional attachment between father and child happens when he makes the cut. This moment is remarkable and symbolizes the overcoming of the difficulties of labor, promoting for the father a shared responsibility framework towards the child, since during the gestation, the mother had the most part of that responsibility.¹⁹ In order for this to happen, it is necessary that health professionals who assist in childbirth offer the opportunity to the companion to cut off the cord, a demonstration of acknowledgement of the father's role as an active participant in the delivery process. Therefore, the importance of having a team sensitive to the specific demands of the various moments involved in childbirth is evident.^{20,21}

In order to make decisions regarding such a singular moment in their lives, women need to gain prior knowledge about the subject. Thus, it is incumbent upon primary health care professionals, during prenatal care, to provide information to women not only about pregnancy, but also about the parturition process.²² One of the resources that can be used by these professionals is the realization of conversation circles about the delivery plan, used in this research.

And for continuity of this care, the professionals that provide assistance in the hospital environment should consider all the work developed by the primary care colleagues during the pregnancy period. This will only be possible when teams from different levels of health care work towards the humanization of care, demystifying beliefs stemming from the interventionist culture and, consequently, implementing the network of care recommended by the Unified Health System.²³

Finally, the study presented limitations such as the impossibility of ensuring that the sample used is generalizable for the local population, since a previous calculation of the proportion of pregnant women residing in the studied districts during the period of data collection was not performed. Further research is needed to better understand and evaluate the quality of prenatal care and the information provided by primary health care professionals to women.

CONCLUSION

The present study allowed us to know the main choices of pregnant women for the time of labor and delivery, through a delivery plan completed by them during their participation in conversation circles. These choices included the desire to be accompanied by the father of the NB, the use of bath or shower to relieve the pain of childbirth, and to give birth in a low-light environment.

These results are extremely important because they inform choices based on the desires of women and on the provision of quality information during the conversation circles. The latter can promote the improvement of the assistance provided by health professionals to women. This implies a model of

assistance no longer standardized, but rather, conformed to the demands presented, respecting the subjectivity of women and the principle of equity.

Therefore, the commitment of professionals towards humanization of childbirth care and through stimulation will boost the parturients to adopt choices unrelated to the interventionist culture. In this way, the quality of delivery care may be closer to the recommendations of the Ministry of Health and the World Health Organization.

Furthermore, this article brings significant contributions to the Brazilian scientific community, since there is a shortage of original publications in Portuguese on the issue of childbirth. This will imply the provision of a holistic nursing care that meets the specificities of women, providing hosting, security and support, granting the desired qualified and humanized assistance. In addition, this will help minimizing the complications from unnecessary interventions.

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