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RESEARCH

A cultura interferindo no desejo sobre o tipo de parto

The culture interfering on the wish about the type of parturition

La cultura interfiriendo en el deseo sobre el tipo de parto

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ABSTRACT

Objective: a qualitative study done at a teaching hospital and a basic health unit in Rio Grande do Sul, from January to March 2011, which aimed understanding to what extent the culture influences the process of women parturition. **Method:** eight women were interviewed and the data were analyzed and interpreted according to the Analysis of Thematic Content. This analysis let to two categories: the women's perception about the kind of parturition wanted, and, the questioning about the resistance to the biomedical model. **Results:** the results show that the kind of birth wanted by the majority of the interviewed was the normal birth, but it was verified that the majority could not accomplish this wish, due to the influence of interventions done by the doctor. **Conclusions:** it was shown by the women a clear unpleasantness for some practices that took out the autonomy from the women in the process of parturition, being one of them the lack of autonomy in the choice of natural delivery. **Descriptors:** culture, nursing, parturition, women's health.

RESUMO

Objetivo: estudo qualitativo realizado em hospital de ensino e uma unidade básica de saúde do Rio Grande do Sul, de janeiro a março de 2011, que objetivou compreender de que forma a cultura influencia no processo de parturição da mulher. **Método:** foram entrevistadas 08 mulheres e os dados foram analisados e interpretados conforme Análise de Conteúdo Temática. Esta análise possibilitou duas categorias: a percepção das mulheres sobre o parto desejado; e, questionamento e resistência ao modelo biomédico. **Resultados:** os resultados mostram que a via de parto desejada pela maioria das entrevistadas foi o parto normal, mas constatou-se que a maioria não conseguiu realizar esse desejo, devido à influência e às intervenções recebidas do médico. **Conclusões:** foi demonstrado pelas mulheres claro desgosto por algumas práticas que retiram da mulher a sua autonomia no processo da parturição sendo uma delas a falta de autonomia na escolha da via de parto normal. **Descritores:** cultura, enfermagem, parto, saúde da mulher.

RESUMEN

Objetivo: es un estudio cualitativo hecho en un hospital de enseñanza y una unidad básica de salud del Río Grande del Sur, de enero a marzo de 2011, que buscó entender de qué manera la cultura influye en el proceso de parto de la mujer. **Método:** fueron entrevistadas 8 mujeres y los datos interpretados y analizados según Análisis de Contenido Temático. Este análisis permitió dos categorías: la percepción de las mujeres sobre el parto deseado; y cuestionamiento y resistencia al modelo biomédico. **Resultados:** los resultados demuestran que la vía de parto deseada por la mayoría de las entrevistadas es la del parto normal, pero se constató que la mayoría no pudo lograr su deseo, debido a la influencia e a las intervenciones recibidas del médico. **Conclusiones:** fue demostrado por las mujeres claro disgusto por algunas prácticas que le quitan su autonomía en el proceso de parto, como la propia autonomía para elegir por la vía de parto normal. **Descriptor:** cultura, enfermería, parto, salud de la mujer.

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INTRODUCTION

The birth conditions show significant distinctions when compared between different global realities. In Western countries, the birth is surrounded by medical technological devices and this medicalization defines it as a physiological dysfunction.¹ Already in Eastern countries, such as Japan, is valued the unmedicated vaginal birth, which, like pregnancy, is not considered disease.²

According to the World Health Organization (WHO), 70% to 80% of pregnancies that occur worldwide are considered low risk; moreover, pregnancy and birth of many high risk pregnancies have a normal course. Organization for normal birth should always be spontaneous with the baby in vertex position between 37 and 42 weeks old, being, birth, mother and son in good condition.

Faced with this, there must always be a valid reason to interfere with this natural process of childbirth, and as a resource for such cases cesarean section, that it is a medical intervention for the extraction of the fetus by cesarean.

Cesarean section is an intervention used in situations where the condition of the mother and the baby do not favor vaginal parturition. However, his incorrect statement is associated with a higher incidence of mortality and morbidity for pregnant women, such as bleeding, puerperal infections, pulmonary embolism, anesthetic risks as well as other pathologies. For babies, the risks are related to respiratory disorders, physiologic jaundice, iatrogenic prematurity, hypoglycemia and anoxia.³

It is noteworthy that information and opinion formation among women in Brazil are priority⁴, so that they can choose the best for your health and for your children, for though professionals and women make early option type of birth, this fact cannot be seen as a simple matter of preference, since cesarean is not a "commodity". However, this does not happen in health care practice, although provided in regulatory and public health policies.

One way to become more attractive and pleasing to the eyes of women the practical convenience for the cesarean section, it is the contradictory concept of this surgery centered on the family, which gives parents options as to the type of anesthetic and therapy indicated for women.⁵

Thus, a super appreciation of caesarean in the general population occurs as a false medical assurance to parents regarding the quality of their offspring and fecundity. By giving answers to obstetric and neonatal problems, which greatly increases the rate of maternal mortality during pregnancy and the postpartum period, medicine created truth discourses.⁶ These discourses are forged together with the relations of power and can only function with the production, accumulation and circulation.⁷

The hegemony of this medical discourse prevails, disregarding, during the birth process, the beliefs and culture of women. It is only the doctor who gives the final word to questions and concerns of women, as it considers its legitimate and unquestionable word.⁸

Thus, the woman loses her autonomy as a protagonist in the birth process disfiguring this act, which until then was purely feminine, for the doctor, as lord and master of parturition, a role reversal that "legitimizes the power and the relationship of medicine with the family".⁹

This reversal of roles in the scenario of labor, in which the physician holds the power over the woman's body, justifies the high cesarean rates in recent decades. The result of this interventionist is the discrepancy between what women want and what is done, which would justify a change in the type of birth.¹⁰

Another implication of this paradigm shift in relation to the birth process is that the birth, postpartum care and newborn, which formerly elapsing the family, and were involved in strong ties, Painless currently in hospitals, where the bonds have become mere superficial contacts, accentuating the loss of autonomy of women in this process.¹¹

The context of birth in our society, shows that the woman in labor is increasingly distant from the condition of the protagonist birth scene: "totally insecure, undergoes all orders and directions, without understanding how to combine the power contained in attitudes and words that hears and sees with the inexorable fact that it is she who is in pain and who will give birth".⁴

The objective of this study is to understand how culture influences the woman in labor process. In this article we will focus on the perceptions and expectations of women about childbirth and questioning and resistance to the biomedical model.

Thus, this study brings reflections those could impact on nursing care provided to women during the period of parturition, as it assists in understanding the needs of care with the mothers, the perception of women about parturition and birth.

METHOD

This is a descriptive study with a qualitative approach,¹² under cultural focus using the theoretical framework of the anthropologist Emily Martin, who proposes an analysis of the phenomenon of confinement, in contrast to the delimitation of the field of biomedical and mechanical reproduction. Searching to understand it as an essential component of women, in order to denature too expensive truths, bounded to modern conceptions linked to nature and culture.

We interviewed eight women of childbearing age with a history of vaginal or cesarean parturition who were not in the pregnancy-puerperal period, and whose births occurred from 2004, as this is the year in which the program was implemented Humanization of Prenatal and Natal in Rio Grande do Sul (RS).

Places of study setting were a university hospital (UH) and a basic health unit (BHU) in the small towns that serve as a training field and classroom practice of graduate students in the health of the Federal University of Santa Maria. Were invited for interviews women who participated in the groups of family planning, and who came in the days pre-

established for dispensing of contraceptives at BHU. In HU, the search for subjects extended to different units of gynecological and obstetric care, accompanying women and women who work in these units and who met the inclusion criteria.

The data collection took place between January and March 2011, using as an instrument the semi-structured interview, with closed questions to characterize the study group, and open questions that allowed the elaboration of the data and obtaining answers related to experience of women. In this type of interview the informant freely discusses the theme, with pre-formulated question, and enables describing their experience retrospectively, without repression of his thought. Collect provides extremely rich material for analysis and contributes to the research work in progress.¹³

The data analysis was performed based on the thematic analysis of Minayo, this ordering must follow the following three steps which are: pre-analysis, material exploration and processing of results and interpretation¹².

To perform all activities of the research looked up at the fundamentals of Resolution n. 196/96, of the National Health Council, which prescribes the ethics on human research. The project was approved by the Ethics Committee of the Federal University of Santa Maria, on June 15th, 2011, under the number Opinion: 23081.018749/2010-36 and CAAE 0317.0.243.000-10.

RESULTS AND DISCUSSION

As categorias que emergiram na análise dos dados e que serão discutidas a seguir são a percepção das mulheres sobre o parto desejado e o questionamento e resistência ao modelo biomédico.

The categories that emerged in the data analysis and will be discussed below are women's perceptions about the desired birth and questioning and resistance to the biomedical model.

The perception of women on the desired birth

When expressing the desired mode of birth, most women expressed a preference for vaginal parturition, but most of these failed to fulfill this desire. Only one interviewee expressed preference for cesarean section and had met his will. *"For me wanted a vaginal birth, so that the first child I would walk down the day before to see if evolved for normal birth, but not evolved, there was cesarean, cesarean section and the other was too. It had to be programmed. "(M6). "I always wanted cesarean because I was afraid of feeling pain there at the time." In my head that I had my first child would be normal. Normal birth mother wins out and already walking with child in lap and cesarean section no."(M8)*

The speech of the participants revealed the desire of normal birth or c-section, highlighting the understanding that vaginal parturition has the fastest recovery, not

interfering in the routine and their autonomy, presents less risk of infection, and that the cesarean section could avoid the pain of childbirth. These points justified, in large part, the preference for particular parturition route.

Women who want a normal birth and can go through this experience consider it a process that happens naturally, as something that women do not simply sees happening⁵, with as outlined in the following reports: *"I wanted to give birth at home (...) I worked until the last hour of hospitalization. It was good, did breathing correctly and ended up winning in the bed, as I thought I wanted to be born."* (M1). *"When I said I wanted natural childbirth told me "why do normal parturition, why not make a cesarean? ". I said" I want a normal parturition for faster recovery so you can return to study "and I found much better than the normal birth have made a cesarean that then I would go days without being able to go back to school."* (M3)

Studies of quantitative and qualitative nature of health area in relation to choice for vaginal birth found that women's expectations in relation to mode of birth were justified by faster postpartum recovery and be better for them and/or babies.¹⁴

The interviewee who performed the cesarean section for own desire justified her choice by fear of parturition pain. The way one perceives and responds to pain may be influenced by cultural and social origin. In other cultural groups, parturition pain is not feared, much unlike women from Western countries, who fear and are quite likely to accept analgesic or anesthetic drugs.¹⁵

In Brazil, the fear of pain is considered one of the causes of cesarean intervention required by women, and can be considered as well, one motivation for the increased rates of this surgery in the country.¹²

In a study¹⁶ about pain of natural birth, the author showed the occurrence of a power relationship of obstetric services on the female body and the way these services manage themselves, keeping the process of medicalization, which constitutes one of the mechanisms facilitating the perpetuation of cesarean section in order to avoid the pain of natural childbirth.

It is also understood that the pain of childbirth is largely iatrogenic extent amplified by healthcare model establishing routines such as immobilization, the abusive use of artificial oxytocin, Kristeller maneuver, episiotomy and episiorrhaphy. These practices are clearly in normal birth harmful or ineffective and should be eliminated based on scientific evidence and WHO¹⁷ recommendations and of the Ministry of Health.⁴

Thus, it was established by the Ministry of Health in 2000, the Program for Humanization of Prenatal and Birth¹⁸, whose goal is to improve obstetric care, generated by practices and misconduct. The program is translated as a humanistic model of care. The professionals in this aspect simply have the desire to humanize technomedicine and the greatest potential to reform the technocratic model, with changes in attitudes and paradigm.¹⁹

In this sense, the choice of mode of birth becomes important, since it takes into account the cultural context and social care where the mother is inserted and the biological and psycho-emotional aspects, aiming to promote a carefully directed to their referring needs²⁰ other health scenarios. Such care approaches humanization of care in childbirth.

Stands out, in the statements of the interviewees in this study, the sense of frustration and loss of control of who wanted a normal parturition and had to undergo cesarean section. *"I had talked to my husband at home and we wanted a normal delivery, but it did not, I lost control."* (M2). *"My preference has always been normal birth, I thought I'd get the normal of the latter, but it did not, I was frustrated."* (M5)

Similar results were found in the account of women⁵ interviewed in Baltimore (USA), which saw the statements that one of the most common reactions, especially when the woman planning a vaginal birth and the surgery takes place, is the loss of control of her birth.

On the other hand, among women who were able to perform normal delivery, depending on their desire to the mode of parturition, the feeling of relief was found.

The sensations of relief, accomplishment, gratitude, awe, run a wide variety of sensations that only the experience of normal birth provides.²¹ *"It was good, wanted a normal birth, did breathing correctly and ended up winning in bed, as I thought I wanted to be born, what a relief."*(M1)

In our study, one of the interviewees reported medical attention for cesarean section in order to submit it to tubal ligation, and his frustrated desire as regards the choice of the birth route once wanted to perform normal birth. It is evident that there was a desire to cesarean but the need for sterilization. *"The normal birth was desired. If you had done a C-section would be the end of the world because it took me to accept the idea that it would make a ligation by cesarean. I have always given the preference for vaginal birth because of comments about having infection."* (M7)

The finding of the disincentive to normal women who had previous histories of normal parturitions made by the medical team to perform a cesarean concomitant tubal ligation, showing disrespect for the law n° 9.263, which deals with family planning childbirth, which seals surgical sterilization in women during periods of childbirth or abortion except in cases of proven need, by successive previous cesarean.²²

The interviewees who underwent cesarean present perceptions of what was done with them and not their participation, as reported in the following sentences: *"took the baby"* (M4), *"punctured me about 15 times"* (M6), *"if the bleeding would not stop taking my uterus"* (M8).

The feeling of passivity and separation between "I" and "body" arises in extreme level when women describe the cesarean. Part of this stems from the fact that a surgery in which a greater number of people touches, handles, cutting and sewing your body, another part is due to epidural anesthesia that produces numbness from the waist down and is intensified by placing a cloth on the breast of the woman so that she does not see the bottom half of your body.⁵

Another important aspect, rescued in the statements of the interviewees in our study shows that, at the time of cesarean section, the bonds between mother and child can be being discouraged by prioritizing up care that could be delayed: *"First the care was conducted the baby and I have already shown wrapped in the clothes."* (M6). *"They were there doing the baby care and showed me right then."* (M8)

Such care, beyond being interfering with loving mother-infant relationship may be ignoring the implementation of simple practices such as delayed cord clamping, immediate

skin-to-skin contact and initiation of exclusive breastfeeding, which has an impact, long-term nutrition and health of the mother and baby, as they affect the development of the child beyond the neonatal period and puerperium.²³

In this direction there is a metaphor for the birth production¹⁷ portraying disruption of emotional bonds between mothers and infants who experienced cesarean, due to the control exercised on the female body by the removal of the role of women in birth scene. This fact resembles the metaphor of industrial production, the non-involvement of working with the product of their labor when she did not feel that was the one who produced it and when your work is strictly organized and controlled.⁵

Often when it interferes with the production of a baby, especially when it is not the woman who gives birth and the baby is surgically extracted by a doctor, the mother feels disconnected from the child after its birth.⁵ A study conducted at the University of the City Cape, South Africa, showed that the separation between mother and baby have negative impacts, influencing sleep duration and heart rate of the baby.²⁴

Furthermore, the model of biomedical care discourages the implementation of proven effective care and passes a message that mother and baby are like a conflict dyad, not being seen as an integral unit.⁵

Another element to be highlighted concerns the perception of being a mother, through the experience of labor, ie, understands the meaning of being a parent through the experience of childbirth, as the interviewee says: *"It was my first child I decided that to be a mother, would have to earn vaginally [...] If it's going to be a mother be a mother myself!"* (M3)

As noted, the interviewee highlights that normal birth was essential to really feel mother. Important in this regard is the statement that birth is a ritual that marks deeply feminine unconscious, especially if the first.¹¹

Questioning and resistance to biomedical model

In this category, it shows the reports of resistance to questioning and obstetric care, by some women, revealing that they do not have much autonomy in deciding the type of birth as the choice for those who want to accompany them in their birth. *"I wish my husband 'had' together. (...) To be more focused. So much more natural for me could be better, choose whether to bathe or not, whether to stay in the water or sit on the ball. (M1). "I think it was very forced. Students, seven to eight people attended my birth. Nobody asked me if I wanted to. I felt invaded. Another fact that made me frustrated was when I started prenatal I said I wanted a normal birth to physician he became angry and was very rude and asked what I was doing there then (...) I changed doctor."* (M3)

Participants questioned the situations imposed by professionals representing the biomedical model. One interviewee who wanted a normal birth was presented encouraged protesting against this model, when exchanging medical had not respected his opinion. Another questions the lack of a companion of your choice in childbirth. Their statements call attention also to the importance of women have more freedom and can exercise active participation, with the right choices. It is also questioned the use of oxytocin and lack of respect for their privacy because they are gifts people watching your

delivery without prior authorization request, which shows disrespect for autonomy in the process.

A woman in labor needs privacy to feel safer. However, in many places of public service that is not properly taken care of, and neglected the culture of the subject, which involves their values, perceptions, needs and fears.²⁵

Also noteworthy is that, as of 2005, Law nº 11.108, went to mothers to ensure the right to the presence of a companion of their choice during labor, parturition and postpartum. In a performed study²⁶ it was found that the presence of relatives in the birth process is seen by 100 % of respondents as paramount. The feeling reported by men who have accompanied their wives in labor is the fullness in no time the female instinct speaks so loudly, is the rebirth of a new woman.²¹

A professional attitude in not accepting the opinion of the users is called by anthropologists as "ethnocentric thinking" or "closed system of cognition". Ethnocentrism is a system marked by rituals that represent and support it.²⁷ Ethnocentric know the existence of other knowledge and beliefs, but they are absolutely certain that their thinking is better and therefore ignore contrary to their ideas and consider these different ways of thinking a threat.

A basic principle of technocratic service model, which comes in the way of thinking and acting of ethnocentric thinking, is the authority and responsibility of the professional and the healthcare institutions on a person cared for. In this context, it is more "comfortable" for the user abdicate their personal preference in favor of medical opinion.²⁷

This fact was noted in the interviews that pointed to the resistance to the biomedical model, however, through a passive perception of reality, as the vague feeling that something is wrong and that change is not within reach, or not only depends on its will and action. *"I am against oxytocin. And put me in the serum oxytocin and I said 'but why put, for I am almost giving birth? Just to give me a stronger pain? 'And I really got it "(M1).*

These women seem to be unaware of the subliminal fragmentation of care to hospital birth, as if the "I" and "body" were separate and that the birth was part of a production. The most effective tactic described,⁵ when you use the analogy between workers and women giving birth, the woman is become "boss" of itself, ie, giving birth in her home, where she is the "owner of the factory "and can have total control over your body and consequently on the process of" production ".

CONCLUSION

We found that the mode of birth desired by most participants was the normal birth, but it was found that most failed to realize this desire, because of the influence and assistance received from the doctor.

The arguments that influenced the discouragement of the vaginal parturition were the need for tubal sterilization, women undergoing a caesarean section, and the lack of information on non-pharmacological and pharmacological methods of pain relief.

It is worth noting that women who wanted a normal birth and have managed to give birth in this way, felt confidence and trust in the experience of parturition, with no clear sign their statements related to the inability to do so, allowing them to thus experience it actively. Other important aspects to be highlighted were the speed of recovery and return to daily activities, the desire to be welcomed by professionals in their demands and the right to clear information and ethics.

The choice of type of birth, signed by some women in the study, covers the manifestation of resistance to questioning of the current biomedical model underlying cultural assumptions, disagreeing with practices that experienced in childbirth, considered them disrespectful. Common point in their speech was self-perception of passive resistance imposed by the medical culture.

It was found dislike of women by some practices that limited their autonomy in the delivery process, such as avoidance of a companion during labor and birth, invasion of privacy with the entry of outsiders to attend the birth without license woman in parturition, and lack of autonomy in the choice of vaginal births.

Thus, it is of utmost importance, when providing assistance during the process of parturition, the recognition of women as protagonists of their birth, the multiple aspects that permeate their experiences being featured. These are essential elements for healthcare professionals understand the fears, joys and pleasures of pregnancy and childbirth and take a new position of attention.

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