

## Assistência obstétrica no processo de parto e nascimento

Obstetric assistance in the process of labor and birth

Asistencia de parto en el proceso de parto y el nacimiento

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### ABSTRACT

**Objective:** Characterize the obstetric care experienced by teachers of a Public University of Minas Gerais, during the last experience of parturition and birth process in a hospital environment. **Methods:** Quantitative cross-sectional study. Data collection occurred in the months of December/2015 to February/2016, with 40 teachers, using a self-administered questionnaire. For data analysis was used the test Mann-Whitney, defined with 5% of significance. **Results:** The most frequent type of birth was the caesarean with 95% (38). The choice of accompanying person was possible to 92.5% (37). The association between the variables choice of accompanying person with the age at last birth, showed statistically significant result. **Conclusion:** can emphasize the need to reflect on the assistance provided to women during the process of parturition and birth is one of the ways to ensure safe motherhood and humanized.

**Descriptors:** Nursing, Obstetric Nursing, Delivery

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## RESUMO

**Objetivo:** caracterizar a assistência obstétrica vivenciada por docentes de uma Universidade Pública de Minas Gerais, durante a última experiência do processo de parto e nascimento em ambiente hospitalar. **Métodos:** estudo descritivo transversal quantitativo. A coleta de dados ocorreu nos meses de dezembro/ 2015 a fevereiro/ 2016, com 40 docentes, usando um questionário de autopreenchimento. Para a análise dos dados utilizou-se o teste Mann-Whitney, definido com 5% de significância. **Resultados:** a via de parto de maior frequência foi a cesariana com 95% (38). A escolha do acompanhante foi possível para 92,5% (37). Na associação entre as variáveis escolha do acompanhante com a idade por ocasião do último parto, apresentou resultado estatisticamente significativo. **Conclusão:** pode-se ressaltar a necessidade de refletir quanto à assistência prestada à mulher durante o processo de parto e nascimento sendo uma das formas de garantir a maternidade segura e humanizada.

**Descritores:** Enfermagem, Enfermagem Obstétrica, Parto

## RESUMEN

**Objetivo:** caracterizar la asistencia obstétrica experimentada por los profesores de una universidad pública de Minas Gerais durante la última experiencia del proceso de parto y nacimiento en el hospital. **Métodos:** cuantitativa estudio transversal. La recolección de datos se desarrolló entre diciembre/2015 a febrero/2016 con 40 profesores, mediante un cuestionario autoadministrado. Para el análisis de datos se utilizó la prueba de Mann-Whitney fijado en el 5% de significación. **Resultados:** El modo más frecuente de entrega fue cesárea con 95% (38). La elección de escolta era posible para 92,5% (37). La asociación entre las variables que acompaña a la elección con la edad al último nacimiento, mostró un resultado estadísticamente significativa. **Conclusión:** Puede ser hecho hincapié en la necesidad de reflexionar sobre la atención que se brinda a las mujeres durante el proceso de parto y el nacimiento es una de las formas de garantizar la maternidad segura y humanizada.

**Descriptorios:** Enfermería, Enfermería Obstétrica, Parto

## INTRODUCTION

Care for childbirth and birth for a long time was focused on the baby, paying attention only to their health conditions and, in a way, forgetting the parturient. With the evolution of obstetric care, in the last decades, the behaviors in the process of childbirth and birth have been reformulated, prioritizing humanized assistance to the mother/child binomial.<sup>1</sup>

The humanization of delivery and birth care privileges the use of all available obstetric technologies and techniques, making the benefits to be obtained greater than the risks to be taken.<sup>2</sup>

According to the Ministry of Health (MS) to lead/ induce labor through medication and surgical or technical maneuvers easing the suffering of the woman is considered a noble task on the part of health professionals, and is being fulfilled. However, there are contradictions regarding technical or surgical interventions and their real consequences in the physiological process of childbirth and in the physical and emotional health of the mother and baby. To interfere with the normal delivery process, a valid reason is necessary to justify such interventions.<sup>2</sup>

The humanization of care proposes, in particular, that health professionals respect the physiological aspects of the birth and birth process, intervene in a judicious way and recognize the social and cultural aspects of the woman, offering her a warm assistance based on respect for her dignity and autonomy.<sup>3</sup>

There is scientific evidence that various practices in gestation and delivery care are conducive to improved obstetric outcomes and are effective in reducing negative perinatal outcomes. On the other hand, inappropriate use of technologies or unnecessary interventions has presented unfavorable maternal and perinatal outcomes and interventionist assistance has been a source of dissatisfaction for women.<sup>3</sup>

In this context, it is worth mentioning that one of the technologies used indiscriminately in Brazil is the cesarean section, with indices considered absurd, placing the country leader in the world ranking. The rate of cesarean deliveries in relation to the total number of deliveries performed in a health service should be between 10 and 15%. In Brazil this rate reaches 54%, and this number grows to 84% of deliveries made by Health Plans, while in the Public Network the number is lower, about 40%.<sup>4-5</sup>

In order for the high rates of cesarean delivery to be reduced in Brazil and the woman receiving qualified care, the professionals responsible for delivering birth and delivery must adopt obstetric practices that guarantee a safe and humane service to the mother/child binomial. In this perspective, WHO initiated discussions on obstetrical practices based on scientific evidence and in 1996 published the Handbook on Normal Childbirth: a practical guide which contains recommendations considering the usefulness, efficacy and substantially the absence of harmful effects in relation to the behaviors and practices of delivery assistance.<sup>6</sup>

The interest in developing this study came from the restlessness experienced by the authors regarding the qualification of obstetric care in the nursing area. Knowing the importance of the performance of qualified nurses in the attention to the mother / child binomial and to guarantee a transformative assistance in the process of birth and birth, Governmental Organs have been committed to qualify the obstetric assistance, with safe and humanized practices, preserving the protagonism Of the woman in such a special moment of her life and the family.

This study aims to characterize the obstetric care experienced by teachers of a Public University of Minas Gerais, during the last experience of the process of childbirth and hospital birth.

## METHODS

This is a cross-sectional descriptive study, with a quantitative methodological approach, carried out at a Public University of Minas Gerais, about obstetric care in the birth and birth process experienced by teachers.

The sample of the present study was composed of 40 women belonging to the faculty of all the presential courses of the Academic Units of the campus I and II of a Public University of Minas Gerais.

The following eligibility criteria were adopted: teachers with at least one normal birth or cesarean delivery experience at hospital level from 2005 onwards, believing it to be a sufficient time for implementation in obstetric care of the Practices Based on Scientific Evidence Published in 2001 by the MS. Data collection occurred in the months of December 2015, January and February 2016.

The data were obtained by means of a questionnaire prepared by the researchers, having as a theoretical reference the Handbook: Childbirth, Abortion and Puerperium: humanized assistance to the woman, from the MS.7 Being used to elaborate the instrument, category A that addresses, practices in the Laboratories that are demonstrably useful and should be encouraged. The questionnaire used was composed of 27 discursive and objective questions, containing the following variables: sociodemographic; Related to the last process of labor and birth; Related to obstetric care during the last birthing process and birth being normal or cesarean.

Teachers were contacted individually, in their workplaces, without interference in their didactic routines. Those that met the inclusion criteria were addressed. After accepting to participate in the research, the reading and signing of the Informed Consent Term (TCLE) was requested, and data collection was started using the self-completion questionnaire, scheduling with the teachers the date for their collection.

The data collected was organized and stored in a database structured in Microsoft Excel®. Later they were imported by the Software Statistical Package for Social Science, version 17.0 for descriptive and inferential statistical analysis. The chi-square test ( $X^2$ ), Mann-Whitney test and Fisher's exact test were used to analyze the relationships between the variables. All tests were defined as 5% ( $p < 0.05$ ) of significance.

The research obeyed the ethical and legal aspects according to the resolution of the National Health Council 466/2012, which refers to research involving human beings.8 And obtained a favorable opinion from the Committee of Ethics in Research (CEP) of UNIFAL-MG, Opinion number 1,294,313.

## RESULTS

Of the total of 40 teachers who participated in the study, 77.5% (31) declared themselves white and 22.5% (9) brown. All of them received care in the last process of labor and delivery through the supplementary / private health system. It was observed that 80% (32) of the participants had the experience of the last process of labor and birth in the age group above 30 years. Being 35% (14) above 35 years, age considered as late maternity.

According to the table 1, the cesarean section was the most frequent way of delivery reaching 95% (38). It is worth mentioning that 73.7% (28) of the interviewed teachers who underwent labor gave birth and 26.3% (10) had elective cesarean.

**Table 1** - Distribution of teachers according to the variables, type of delivery, date of last childbirth and the place where the care was given - Alfenas - MG, 2016. (n=40)

Variables	N° of professors	Percentage (%)
<b>Type of birth</b>		
Normal	2	5,0
Cesarean section	38	95,0
TOTAL	40	100,0
<b>Date of last childbirth (years)</b>		
≤ 3	13	32,5
4 a 6	14	35,0
7 a 10	13	32,5
TOTAL	40	100,0
<b>Place where the service was received (State)</b>		
Minas Gerais	28	70,0
São Paulo	11	27,5
No answer	1	2,5
TOTAL	40	100,0

Source: authors

Regarding the date of the last delivery, which occurred in the last 10 years, a homogeneous distribution is observed between the intervals presented. It is worth mentioning that the date chosen as the eligibility criterion was from 2005 onwards, believing it to be a sufficient time for implementation in obstetric care of the Practices Based on Scientific Evidence published in 2001 by the MS. The majority of deliveries were attended in maternity wards of the State of Minas Gerais, 70% (28) and of these, 85.7% (24) occurred in Alfenas.

**Table 2** - Distribution of teachers according to the variables, choice of type of delivery, choice of institution where the delivery took place and choice of the professional who gave birth - Alfenas - MG, 2016. (n=40)

Variables	N° of professors	Percentage (%)
<b>Choice of delivery type</b>		
Yes	16	40,0
No	24	60,0
TOTAL	40	100,0
<b>Choice of the institution where the delivery took place</b>		
Yes	35	87,5
No	5	12,5
TOTAL	40	100,0
<b>Choice of birth attendant</b>		
Yes	38	95,0
No	2	5,0
TOTAL	40	100,0

Source: authors

A maioria das docentes, 60% (24) não puderam opinar em relação ao tipo de parto a que foram submetidas; 87,5% (35) e 95% (35) escolheram respectivamente a instituição e o profissional que as atenderam (Tabela 2). Entre elas 92,5% (37) tiveram a liberdade de escolha do acompanhante durante o processo de parto e nascimento, 5% (2) não tiveram seu direito respeitado e 2,5% (1) não respondeu.

No que se refere à presença do acompanhante durante o processo de parto e nascimento, 52,5% (21) estiveram presentes durante o trabalho de parto, 25% (10) não entraram em trabalho de parto, 62,5% (25) permaneceram durante o parto e 90% (36) se mantiveram após o parto (Tabela 3).

**Table 3** - Distribution of teachers according to variables, presence of the companion during labor, during delivery and after delivery - Alfenas - MG, 2016. (n=40)

Variables	N° of professors	Percentage (%)
<b>Presence of the companion during labor</b>		
Yes	21	52,5
No	9	22,5
Does not apply	10	25,0
TOTAL	40	100,0
<b>Presence of the companion during the delivery</b>		
Yes	25	62,5
No	15	37,5
TOTAL	40	100,0
<b>Presence of the accompanying person after childbirth</b>		
Yes	36	90,0
No	4	10,0
TOTAL	40	100,0

Source: authors

The team was helpful about the doubts and questioning to 85% (34) of the interviews and 95.0% (38) were informed about the need for the usual tests such as touch, uterine dynamics, auscultation of BCF (Fetal Cardiac Beats) and Serology of HIV (Human Immunodeficiency Virus) and VDRL (Venereal Disease Research Laboratory).

It was found through the results of the research, that the majority of participants 87.5% (35) were informed about the need for cesarean section indication. The medical indications for cesarean section were: stationary labor, previous cesarean section, oligohydramnios, advanced maternal age, cord circular, twin gestation, twin pregnancy with pelvic presentation, borderline gestational age, baby was not fitted and anatomical alteration in the cervix uterine. There were cases of emergency cesarean delivery, the justification of which was fetal distress at 29 weeks' gestation and an amniorrhexis at 36 weeks' gestation.

Regarding the information received about the risks to mother and child that were exposed to the surgical procedure among the 38 participants submitted to it, 60.5% (23) received such information, 29% (11) were not informed and 10.5% (4) did not respond to the question.

During labor, 83.3% (25) of teachers were not allowed freedom of position and 93.3% (28) received no liquid. Most teachers, 90% (27), did not receive non-pharmacological measures for pain relief, but for three of them it was offered: acupuncture, Swiss ball and relaxation technique (Table 4).

**Table 4** - Distribution of teachers according to the variables, helpful staff in the face of doubts and questions, and information regarding the performance of exams - Alfenas - MG, 2016. (n=40)

Variables	N° of professors	Percentage (%)
<b>Helpful staff with doubts and questions</b>		
Yes	34	85,0
No	6	15,0
TOTAL	40	100,0
<b>Information regarding the performance of exams</b>		
Yes	38	95,0
No	2	5,0
TOTAL	40	100,0

Source: authors

In the first hour after birth, breastfeeding was stimulated to 50% (20) of the participants; at 60% (24) skin-to-skin contact was provided, and 70% (28) of the newborns were housed together (Table 5).

**Table 5** - Distribution of teachers who entered labor according to variables, freedom of position, fluid intake and use of non-pharmacological measures for pain relief - Alfenas - MG, 2016. (n=30)

Variables	N° of professors	Percentage (%)
<b>Freedom of position during labor</b>		
Yes	5	16,7
No	25	83,3
TOTAL	30	100
<b>Fluid intake during labor</b>		
Yes	2	6,7
No	28	93,3
TOTAL	30	100
<b>Use of non-pharmacological measures for pain relief</b>		
Yes	3	10
No	27	90
TOTAL	30	100

Source: authors

The results of statistical associations between the variables presented a statistically significant result only in the association between the variables of choice of the companion and the age at the last birth, evidencing that 92.5% (37) were respected with a mean age of 34.92 Years, according to the Mann-Whitney test, with  $p = 0.016$ .

In the result regarding the presence of the companion during the delivery, although it did not present a statistically significant result, there was an increase in the presence of the companion in the parturients, with the following results: in the period  $\leq 3$  years 27.5% (11); From 4 to 6 years 22.5% (9); From 7 to 10 years 12.5% (5), and it can be understood that the legislation guaranteeing this right to women has been increasingly respected over the years.

## DISCUSSION

With the changes in society, and the increase of women's participation in the labor market and in all the economic and political sectors of the country, late motherhood has become common among women in the world today.<sup>9</sup> It is considered late maternity when Gestation occurs after 35 years of age, although some studies indicate that the age group of 40 years or more defines the term more appropriately.<sup>10</sup>

Women who choose to become pregnant as early as the fourth decade of life, are part of the population that has more education and a stabilized professional career. Most of the time these women are those who have better socioeconomic conditions, family planning, are in good health and gestation is monitored periodically by a health team.<sup>10-11</sup>

Women's obstetrical decisions are influenced by a number of factors, including the way information is passed on by health professionals about possible birth routes, the risks and benefits of both, likely complications and future

repercussions, and a direct relationship in the positioning of the woman facing the type of delivery.<sup>12</sup>

Women who opt for a cesarean section or who accept it on medical advice imagine that this type of delivery is painless and preserves the anatomy of the vagina for intercourse.<sup>13</sup>

Even with the development of technology, cesareans are not risk free, there is a greater chance of developing puerperal infection, maternal and neonatal morbidity and mortality, a longer period of separation between mother and baby due to the surgical routine, which leads to a delay and difficulty in lactation, as well as longer hospitalization and recovery.<sup>14</sup>

Caesarean section is a technology that saves lives, being an alternative for complications during pregnancy or natural childbirth. Doctors and women have been showing increasing interest in cesarean section over the past two decades, thus showing that many cesarean deliveries are medically unnecessary.<sup>13,15</sup>

Although at a very low index, evidenced in the present research, it is known that delivery via vaginal delivery facilitates better initiation of breastfeeding, lower risk of infection and hemorrhage, recovery and early hospital discharge, and lower sensitivity in the postpartum period. The WHO recommends, therefore, that cesarean sections correspond to a maximum of 15% of the total deliveries and are indicated only in relation to risk to the mother or baby.<sup>13</sup>

Often the preference of many women for natural childbirth is observed. This is due to the fact that it allows a healing, recovery and return to the fastest daily activities. However, there are many negative perceptions about this way of delivery, including fear of pain during labor and delivery, triggering of urinary and fecal incontinence, major perineal lacerations, and obstetric violence experienced by known people.<sup>15-16-17</sup>

The autonomy of the pregnant woman regarding the choice of the type of delivery should be respected and maintained whenever possible, however the decision should be shared with the professional responsible for the follow-up of the pregnant woman, thus ensuring that her choice does not endanger the outcome of the process of labor and childbirth. Often the options of professionals and institutions that health plans offer do not meet the wishes of pregnant women.

In fact, it is fundamental to stimulate a closer approximation of the pregnant woman with the professional that accompanies the prenatal care, thus ensuring full and quality care for the woman. Stimulating her confidence and safety regarding the two routes of delivery, since the indication according to medical criteria may not contemplate the preference of the parturient. Thus the pregnant woman can decide with confidence the way of birth for which her child will be born.<sup>12</sup>

It is necessary to remember that the empowerment of women during care in the birth and delivery process should be maintained and stimulated, so that the autonomy in

making decisions regarding their own life and health care positively influence the quality of services offered to her.<sup>18</sup>

In order to reinforce the right of women to share with their doctor the choices inherent in the process of childbirth and birth, in 2005 Law no. 11.108, which assures parturient women the right to be accompanied by a companion of their own choice during the period of labor, delivery and immediate postpartum, which is one of the principles of humanized care.<sup>19</sup>

The data set suggests that the presence of a companion chosen by the parturient, a person of her confidence, enables her to feel emotionally and physically supported, as well as encouraged and safe during the labor process, favoring a good evolution of the pregnancy period -puerperal. In addition to helping women in communication with the team and minimizing stressors.<sup>16,20</sup>

Evidence that an intensive and participatory company during labor, delivery and postpartum can minimize fears and calm women who experience it has led to the recommendation that this support should be offered to all women.<sup>21</sup>

Even in view of the importance of the companion during labor, some institutions and professionals deny parturient such a right. Women, on the other hand, are aware of this legislation, but do not trust that services will respect their rights, are afraid of confrontation and retaliation during hospitalization if they insist on having a companion.<sup>21</sup>

During labor, respect for the intimacy and privacy of the parturient must be strictly obeyed. The health team should perform procedures that are proven to be beneficial to the mother/child binomial, avoiding unnecessary interventions, thus preserving their privacy and autonomy.<sup>7</sup> In the present study, most teachers, 90% (36), reported that they were respected.

The woman in her right to choose, within the ethical principles must be informed in advance about the indications of the operative childbirth even before its accomplishment, not during or after the procedure. This allows the woman to express her feelings and doubts.<sup>22</sup>

The most important task for a caregiver is to ensure the comfort and satisfaction of the woman during childbirth. With this objective and covering the valuation of physiological delivery, the role of women and the adequate use of technologies in the delivery and delivery of childbirth, some practices have been included in the assistance to the parturient woman.<sup>23-24</sup>

The comfort strategies are the stimulus to body movement, freedom of position and active postures during labor and delivery, which are associated with shorter duration of labor, reducing maternal pain, facilitating maternal-fetal circulation, Descent of the fetus into the maternal pelvis, as well as improving uterine contractions and reducing perineal trauma. These strategies are considered to be methods of women's empowerment bringing a new conception of power,

encouraging them to be protagonists of the process of birth and birth.<sup>23-24</sup>

Many maternity hospitals still restrict feeding and fluid intake from the parturient. MS recommends, under normal conditions, low-risk parturients and usual risk, provide liquids and a light diet. Fasting can lead to dehydration and acidosis, which added to the fatigue of the pregnant woman in labor increase the possibility of a cesarean section and greater blood loss after giving birth. However, if pain relief medications are used, the woman in labor must stop eating and only water in small quantities.<sup>25</sup>

Among the non-drug practices for pain relief, the use of relaxation and breathing techniques has been studied which, in addition to reducing pain sensation, improve maternal blood saturation levels of O<sub>2</sub>, provide relaxation and decrease anxiety.<sup>24</sup>

Another alternative is the use of the Swiss ball, where the parturient can sit with the spine well aligned, without discomfort, performing exercises that help the descent and also relieve the pain.<sup>23</sup>

The set of practices, routines and the quality of the human resources of the maternities can interfere or make impossible the skin-to-skin contact, breastfeeding in the first hour of life of the RN, and the joint accommodation. In addition to some situations and interferences with the NB and mother, such as emergency hospitalization in the Neonatal Intensive Care Unit (Neonatal Intensive Care Unit), as mentioned by a participant in the present study.

In the immediate period after birth, mother and child contact should be stimulated, since it is a time of greater sensitivity of the puerpera and a period of alertness of the newborn. Therefore, whenever the conditions of the mother and the newborn allow the first skin-to-skin contact and breastfeeding stimulation during the first hour of life, they should still be performed in the delivery room.<sup>26-27</sup>

Breastfeeding immediately after birth promotes early mother-infant interaction, warms and calms the newborn, stimulates immune protection, reduces neonatal mortality, aids in uterine contractions, reduces the risk of bleeding, and provides an ideal environment for Adaptation of the newborn to extrauterine life.<sup>27</sup>

After the procedures for caring for the newborn, the baby is in good condition, he/she should move to a place where he/she can stay with his/her mother during their hospitalization.<sup>28</sup> These measures are the best way to start the life of the newborn, because it assures and stimulates the experience of breastfeeding and the affective bond, besides encouraging participation in the care of the child, so they should be stimulated by professionals.<sup>29</sup>

## CONCLUSION

The modification suffered in the assistance provided by the health team over the years, in order to guarantee the rights to a humanized, safe and quality service to the mother / child binomial, can be verified. However some professionals and institutions still resist implementing practices recommended by the Ministry of Health.

The health team should know the best scientific evidence available, together with the risk classification, so they can determine if there is a real need for intervention. In addition to stimulating the feeling of empowerment of women during prenatal care, encouraging their active participation in the construction of their choices.

The nurse practitioner plays a fundamental role in qualified and humanized care in the process of childbirth and birth, since it is the one who will be fully on the parturient's side, so her assistance must be based on strategies for the humanization of care, respecting the physiology, avoiding unnecessary intervention.

## REFERENCES

1. Souza TG, Gaíva MAM, Modes PSSA. A humanização do nascimento: percepção dos profissionais de saúde que atuam na atenção ao parto. *Rev. Gaúcha Enfermagem* [periódico online] 2011[acesso em 02 jun. 2015] 32(3): 479-86p. Disponível em: [www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1983-14472011000300007](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1983-14472011000300007).
2. Brasil. Ministério da saúde. Caderno Humaniza SUS: Humanização do parto e nascimento. Brasília, DF, 2014.
3. Souza CM, Ferreira CB, Barbosa NR, Marques JF. Equipe de enfermagem e os dispositivos de cuidado no trabalho de parto: enfoque na humanização. *Revista de Pesquisa: Cuidado é Fundamental Online* [periódico online] 2013[acesso em 02 jun. 2016] 5(4): 743-54p. Disponível em: [www.seer.unirio.br/index.php/cuidadofundamental/article/view/2380/pdf\\_960](http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/2380/pdf_960).
4. Brasil. Ministério da Saúde. DATASUS. Sistema de Informações sobre Nascidos Vivos (SINASC): Indicadores e Dados Básicos [periódico online] 2011[acesso em 10 jul. 2015]. Disponível em: [www.tabnet.datasus.gov.br/cgi/tabcgi.exe?idb2012/f08.def](http://www.tabnet.datasus.gov.br/cgi/tabcgi.exe?idb2012/f08.def).
5. Organização Mundial da Saúde (OMS). Declaração da OMS sobre Taxas de Cesáreas [periódico online] 2015[acesso em 10 jul. 2015] Disponível em: [www.apps.who.int/iris/bitstream/10665/161442/3/WHO\\_RHR\\_15.02\\_por.pdf?ua=1&ua](http://www.apps.who.int/iris/bitstream/10665/161442/3/WHO_RHR_15.02_por.pdf?ua=1&ua).
6. Silva RC, Soares MC, Jardim VMR, Kerber NPC, Meincke SMK. O discurso e a prática do parto humanizado de adolescentes. *Rev. Texto e contexto - enfermagem.* [periódico online] 2013[acesso em 10 jul. 2015] 22(3): 629-36p. Disponível em: [www.scielo.br/scielo.php?pid=S0104-07072013000300008&script=sci\\_arttext](http://www.scielo.br/scielo.php?pid=S0104-07072013000300008&script=sci_arttext).
7. Brasil. Ministério da saúde. Parto, aborto e Puerpério: Assistência Humanizada à Mulher. Brasília, DF, 2001.
8. Brasil. Ministério da saúde. Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. [periódico online] 2012[acesso em 10 jul. 2015]. Disponível em: [www.conselho.saude.gov.br/resolucoes/2012/Reso466.pdf](http://www.conselho.saude.gov.br/resolucoes/2012/Reso466.pdf).
9. Lopes MN, Dellazzana-Zanon LL, Boeckel MG. A Multiplicidade de Papéis da Mulher Contemporânea e a Maternidade Tardia. *Rev. Temas em Psicologia, Ribeirão Preto* [periódico online] 2014[acesso em 10 jul. 2015] 22(4): 917-28p. Disponível em: [www.pepsic.bvsalud.org/scielo.php?script=sci\\_arttext&pid=S1413-389X2014000400018](http://www.pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1413-389X2014000400018).
10. Silva JLCF, Surita FGC. Idade materna: resultados perinatais e via de parto. *Rev. Brasileira de Ginecologia Obstetrícia,* [periódico online] 2009[acesso em 05 mar. 2016] 32(7):321-25p. Disponível em: [www.scielo.br/pdf/rbgo/v31n7/v31n7a01.pdf](http://www.scielo.br/pdf/rbgo/v31n7/v31n7a01.pdf).
11. Oliveira RB, Galdino DP, Cunha CV, Paulino EFR. Gravidez após os 35: uma visão de mulheres que viveram essa experiência. *Rev. Eletrônica Corpus et Scientia* [periódico online] 2011[acesso em 05 mar. 2016] 7(2):99-112p. Disponível em: [www.apl.unisuam.edu.br/revistas/index.php/corpusetscientia/article/view/134/103](http://www.apl.unisuam.edu.br/revistas/index.php/corpusetscientia/article/view/134/103).
12. Silva SPC, Prates RCG, Campelo BQA. Parto normal ou cesariana? Fatores que influenciam na escolha da gestante. *Rev. Eletrônica Enfermagem da UFSM (Universidade Federal de Santa Maria)* [periódico online] 2014[acesso em 05 abr. 2016] 4(1):1- 9p. Disponível em: [www.periodicos.ufsm.br/reufsm/article/view/8861/pdf](http://www.periodicos.ufsm.br/reufsm/article/view/8861/pdf).
13. Junior TL, Steffani JA, Bonamigo EL. Escolha da via de parto: expectativa de gestantes e obstetras. *Rev. Bioética* [periódico online] 2013[acesso em 05 maio 2016] 21(3):509-17p. Disponível em: [www.revistabioetica.cfm.org.br/index.php/revista\\_bioetica/article/viewFile/798/934](http://www.revistabioetica.cfm.org.br/index.php/revista_bioetica/article/viewFile/798/934).
14. Bittencourt F, Vieira JB, Almeida ACCH. Concepção de gestantes sobre o parto cesariano. *Rev. Eletrônica Cogitare Enfermagem* [periódico online] 2013[acesso em 05 mar. 2016] 13(3):515-20p. Disponível em: [www.ojs.c3sl.ufpr.br/ojs/index.php/cogitare/article/view/33565/21063](http://www.ojs.c3sl.ufpr.br/ojs/index.php/cogitare/article/view/33565/21063).
15. Domingues RMSM, Dias MAB, Pereira M N, Torres JA, d'Orsi E, Pereira APE, et al. Processo de decisão pelo tipo de parto no Brasil: da preferência inicial das mulheres à via de parto final. *Cadernos de Saúde Pública,* [periódico online] 2014[acesso em 28 mar. 2016] 30:101-16p. Disponível em: [www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0102-311X2014001300017](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2014001300017).
16. Qian X, Smith H, Zhou L, Liang J, Garner P. Evidence-based obstetrics in four hospitals in China: An observational study to explore clinical practice, women's preferences and provider's views. *BMC PregnancyandChildbirth,* [periódico online] 2001[acesso em 20 maio 2016] 1(1). Disponível em: [www.biomedcentral.com/articles/10.1186/1471-2393-1-1](http://www.biomedcentral.com/articles/10.1186/1471-2393-1-1).
17. Oliveira SMJV, Riesco MLG, Miya CFR, Vidotto. Tipo de parto: expectativas das mulheres. *Rev. Latino Americana de Enfermagem* [periódico online] 2002[acesso em 20 maio 2016] 10(5): 667-74p. Disponível em: [www.scielo.br/scielo.php?script=sci\\_arttext&pid=S010411692002000500007&lng=en&nrm=iso&tlang=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S010411692002000500007&lng=en&nrm=iso&tlang=pt).
18. World Health Organization. Department of Reproductive Health and Research. *Strategiestowardendingpreventable maternal mortality (EPMM).* 2015.
19. Brasil. Ministério da Saúde. Lei n. 11.108 de 7 de abril de 2005, Brasília- DF [periódico online] 2005[acesso em 30 mar. 2016] Disponível em: [www.planalto.gov.br/ccivil\\_03/\\_Ato2004-2006/2005/Lei/L11108.htm](http://www.planalto.gov.br/ccivil_03/_Ato2004-2006/2005/Lei/L11108.htm).
20. Teles LMR, Pitombeira HCS, Oliveira AS, Freitas LV4, Moura ERF, Damasceno AKC. Parto com acompanhante e sem acompanhante: A opinião das puérperas. *Rev. Eletrônica Cogitare Enfermagem* [periódico online] 2010[acesso em 05 abr. 2016]15(4) 688-94p. Disponível em: [www.ojs.c3sl.ufpr.br/ojs/index.php/cogitare/article/view/20366/13527](http://www.ojs.c3sl.ufpr.br/ojs/index.php/cogitare/article/view/20366/13527).
21. Diniz CSG, d'Orsi E, Domingues RMS, Torres JA, Dias MAB, Schneck CA, et al. Implementação da presença de acompanhantes durante a internação para o parto: dados da pesquisa nacional Nascer no Brasil. *Cadernos de Saúde Pública* [periódico online] 2014[acesso em 20 abr. 2016] 30:140-53p. Disponível em: [www.scielo.br/pdf/csp/v30s1/0102-311X-csp-30-s1-0140.pdf](http://www.scielo.br/pdf/csp/v30s1/0102-311X-csp-30-s1-0140.pdf).
22. Oliveira SMJV, Riesco MLG, Miya CFR, Vidotto P. Tipo de parto: expectativas das mulheres. *Rev. Latino Americana de Enfermagem* [periódico online] 2002[acesso em 05 abr. 2016] 10(5):667- 74. Disponível em: [www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0104-1692002000500007&lng=en&nrm=iso&tlang=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-1692002000500007&lng=en&nrm=iso&tlang=pt).
23. Silva LM, Oliveira SMJV, Silva FMB, Alvarenga MB. Uso da bola suíça no trabalho de parto. *Rev. Acta Paulista de Enfermagem* [periódico online] 2011[acesso em 05 abr. 2016] 24(50):656-62. Disponível em: [www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0103-21002011000500010](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-21002011000500010).
24. Nascimento NM, Progianti JM, Novoa RI, Oliveira TR, Vargens OMC. Tecnologias não invasivas de cuidado no parto realizadas por enfermeiras: a percepção de mulheres. *Rev. Escola Anna Nery de Enfermagem* [periódico online] 2010[acesso em 20 abr. 2016] 14(3):456-56p. Disponível em: [www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1414-81452010000300004](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-81452010000300004).
25. Brasil. Ministério da Saúde. Campanha: Promoção da saúde - SUS. Incentivo ao parto normal. Recomendação para alimentação e ingestão de líquidos durante o trabalho de parto. Brasília- DF, 2015.

26. Mercer JS, Owens DAE, Graves B, Haley MM. Evidence-Based Practices for the Fetal to Newborn Transition. American College of Nurse-Midwives [periódico online] 2007 [Acesso em 20 maio 2016] 52(3). Disponível em: [www.onlinelibrary.wiley.com/doi/10.1016/j.jmwh.2007.01.005/pdf](http://www.onlinelibrary.wiley.com/doi/10.1016/j.jmwh.2007.01.005/pdf).
27. Boccolini CS, Carvalho ML, Oliveira MIC, Vasconcellos AGG. Fatores associados à amamentação na primeira hora de vida. Rev. Saúde Pública [periódico online] 2011 [Acesso em 15 abr. 2016] 45(1):69-78p. Disponível em: [www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0034-89102011000100008&lng=en&nrm=iso&tlng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102011000100008&lng=en&nrm=iso&tlng=pt).
28. Silva BM, Farias MCAD, Sousa AKA, Abreu RMSX, Silva RA. Atuação da enfermagem em alojamento conjunto: percepção de puérperas. Rev. Brasileira de Educação e Saúde [periódico online] 2015 [Acesso em 05 abr. 2016] 5(3):35-44p. Disponível em: [www.gvaa.com.br/revista/index.php/REBES/article/view/3664/3311](http://www.gvaa.com.br/revista/index.php/REBES/article/view/3664/3311).
29. Strapasson MR, Fischer ACS, Bonilha ALL. Amamentação na primeira hora de vida em um hospital privado de Porto Alegre/RS - Relato de experiência. Rev. Eletrônica Enfermagem da UFMS (Universidade Federal de Santa Maria) [periódico online] 2011 [Acesso em 27 abr. 2016] 1(3):489-96p. Disponível em: [www.periodicos.ufsm.br/reufsm/article/view/2824/24](http://www.periodicos.ufsm.br/reufsm/article/view/2824/24).

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