Women's autonomy in the process of labour and childbirth: integrative literature review

Autonomia feminina no processo de parto e nascimento: revisão integrativa da literatura

Autonomía femenina en el proceso de parto y nacimiento: revisión integradora de la literatura

Thamiza Laureany da Rosa dos Reis[a]
Stela Maris de Mello Padoin[a]
Thayla Rafaella Pasa Toebe[b]
Cristiane Cardoso de Paula[a]
Jacqueline Silveira de Quadros[a]

How to cite this article:
Reis TLR, Padoin SMM, Toebe TFP, Paula CC, Quadros JS. Women's autonomy in the process of labour and childbirth: integrative literature review. Rev Gaúcha Enferm. 2017 Mar;38(1):e64677. doi: http://dx.doi.org/10.1590/1983-1447.2017.01.64677.

doi: http://dx.doi.org/10.1590/1983-1447.2017.01.64677

ABSTRACT

Objective: To identify the available evidence in scientific literature on healthcare practices that interfere with the autonomy of Brazilian women in the labour and delivery process.

Method: The search for papers was conducted in the databases LILACS, Scopus and PubMed, between 1996 and 2015, according to a guiding question and exclusion criteria, resulting in the selection of 22 papers to compose the analytic body.

Results: The main practices that favoured the exercise of women's autonomy were out-of-hospital care practices; care practices of support and comfort; and educational care practices. By contrast, the practices that limited autonomy were authoritarian care practices; standardised or routine care practices; care practices that intensify the painful sensation of childbirth; and impersonal and cold care practice.

Conclusion: There was an alarming contrast between the daily healthcare routine and ministerial recommendations.

Keywords: Women's health. Obstetrics. Parturition. Personal autonomy. Patient preference. Decision making.

RESUMO

Objetivo: Identificar as evidências disponíveis na produção científica acerca das práticas de assistência à saúde que interferem no exercício da autonomia das mulheres brasileiras no processo de parto e nascimento.

Método: A busca dos artigos foi desenvolvida nas bases de dados LILACS, Scopus e PubMed, no período entre 1996 e 2015, tendo como eixo orientador a questão norteadora e os critérios de exclusão, sendo selecionados 22 artigos como *corpus* de análise.

Resultados: Foram evidenciadas como práticas que favorecem o exercício da autonomia feminina: práticas assistenciais extra-hospitalares; práticas assistenciais de apoio e conforto; e práticas assistenciais educativas. Em contrapartida, revelaram-se como práticas limitantes ao exercício da autonomia: práticas assistenciais autoritárias; práticas assistenciais padronizadas ou rotineiras; práticas assistenciais que intensificam a sensação dolorosa do parto; e prática assistencial impessoal e fria.

Conclusão: Revelou-se uma situação de alerta relativa ao grande descompasso existente entre o cotidiano assistencial e as recomendações ministeriais.

Palavras-chave: Saúde da mulher. Obstetrícia. Parto. Autonomia pessoal. Preferência do paciente. Tomada de decisões.

RESUMEN

Objetivo: Identificar la evidencia disponible en la literatura científica acerca de las prácticas de atención de salud que interfieren con el ejercicio de la autonomía de las mujeres brasileñas en el proceso de parto y el nacimiento.

Método: La búsqueda de artículos se desarrolló en las bases de datos LILACS, Scopus y en PubMed, en el período comprendido entre 1996 y 2015, con el principio rector de los rectores criterios de interrogación y exclusión, y seleccionó 22 artículos como un corpus de análisis.

Resultados: Hemos puesto de relieve las prácticas que favorecen el ejercicio de la autonomía de la mujer: las prácticas de atención ambulatoria; prácticas de apoyo y consuelo; prácticas educativas y atención. Por el contrario se han demostrado como una limitación del ejercicio práctico de la autonomía: las prácticas de atención autoritarias; prácticas de cuidados estandarizados o de rutina; cuidado prácticas que mejoran la sensación dolorosa del parto; y la práctica de la atención impersonal y fría.

Conclusión: Se puso de manifiesto una situación de alerta en el gran desajuste entre su vida cotidiana y recomendaciones ministeriales.

Palabras clave: Salud de la mujer. Obstetricia. Parto. Autonomía personal. Prioridad del paciente. Toma de decisiones.

[a] Universidade Federal de Santa Maria (UFSM), Departamento de Enfermagem, Programa de Pós-graduação em Enfermagem. Santa Maria, Rio Grande do Sul, Brasil.

[b] Universidade Federal de Santa Maria (UFSM), Departamento de Enfermagem, Curso de Enfermagem. Santa Maria, Rio Grande do Sul, Brasil.

INTRODUCTION

The birth of a child is associated with the renewal of life, and, for many, it is one of the most intense and significant moments of human existence[1]. Due to the specific social, economic, and biological specificities of childbirth, the care provided during this event must focus on the needs of the new mothers, their rights, and their active participation in the process of parturition[2-3].

However, these rights and the preconditions for health and citizenship have been gradually violated. The current obstetric care model is characterised by growing dependence on technical and technological interventions and the wide use of C-section as a way of birth, which has expropriated women of the control over their bodies and of their autonomy[4-5].

Since the 1980s, the feminist movement and other sectors of society have been criticising this technocratic obstetric model in the hope of helping women regain their autonomy during childbirth. They mainly questioned the care provided during the gravid-puerperal cycle, the institutionalisation of childbirth, and the routine use of unnecessary interventions. This movement culminated in conferences, documents, and the search for scientific evidence that could combine several fields of knowledge[3].

An understanding of the impact of gender relations in women's health has led to the expansion of health policies from the perspective of comprehensive care. In recent decades, the ministry of health has proposed programmes and policies to guarantee the civil, sexual, and reproductive rights of women and children. The programme for humanisation in the prenatal and birth[6] established in 2000 chiefly aims to improve access, coverage, and the quality of prenatal monitoring, and care during childbirth and the puerperal period for pregnant women and the newborn.

Expanding the vision of childbirth beyond the biological aspects of women and children, while focusing on the recognition of their rights, is considered incontestable. This integrative literature review is based on the need to discuss the role of women in childbirth and their difficulties in autonomously[2] caring for themselves and their child. The aim of this review is to identify the available evidence in scientific production of healthcare practices that interfere with the autonomy of Brazilian women in the process of labour and birth.

METHOD

This is the study of an integrative literature review according to the proposed six-step methodology[7]. The first step was the selection of the subject and the guiding question: Which healthcare practices interfere in the exercise of autonomy of Brazilian women in the process of labour and childbirth?

In the second step, we defined the inclusion criteria, namely research papers conducted in Brazil that respond to the subject, published in Portuguese, English or Spanish, between 1996 and 2015, and available in full online. We only selected studies conducted in Brazil due to the provided obstetrics care model. Regarding the timeframe, the period from 1996 to 2015 was selected due to the intense humanisation movement and qualification of obstetric care based on the publication by the World Health Organization (WHO) of the "WHO Recommendations – Good Practices for Normal Labour and Delivery"[8]. Since we specifically searched for evidence of healthcare practices in childbirth regardless of the type/method of birth, studies that focused on the method of birth and on the presence of chaperones were excluded.

The search of papers was conducted at the following databases: Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS), PubMed, and Scopus. Given the specific characteristics of the selected databases, the search strategies were adapted for each paper based on the guiding question of the review and the inclusion criteria adopted by the researchers.

In the LILACS database, we used the controlled descriptors obtained from the following health sciences descriptors ("DeCS"): "tocologia" or "parto" or "parto humanizado" or "parto normal" or "parto obstetrico" or "trabalho de parto" or "saude reprodutiva" or "cesarea". These descriptors were combined using the Boolean operator AND with words defined from the concept of autonomy, namely "decisao" or "autonomia" or "direito" or "preferencia" or "escolha" or "participacao". This strategy was used to increase the possibility of finding evidence to answer the research question.

With the same purpose, in the two databases Scopus and PubMed, the keywords were "midwifery" or "parturition" or "humanizing delivery" or "reproductive health" AND "autonomy" or "patient reference" or "decision", and the selection of the item "All Fields" for all the keywords. The studies were surveyed in January 2016. When the full text was not available in the database, the search strategies were totally exhausted by contacting the authors and the institutions of origin of the papers. Duplicate studies were analysed only once.

Subsequently, two reviewers independently selected 22 papers to form the body of analysis. In case of disagreements, the papers were analysed by a third reviewer (Figure 1). To minimise potential errors of interpretation, two

independent reviewers also performed the searches, evaluations, and analyses of the papers.

The fourth step was the analysis, for which each paper was classified according to the information that would answer the investigation question and in relation to the level of evidence. The method used to classify the power of evidence proposes three levels, namely: 1 – Intervention or diagnosis; 2 – Prognosis or etiology; and 3 – Meaning. In view of the body of this research, we used the classification of evidence from studies with a clinical question that is directed toward the meaning, with the following hierarchy: I – Meta-synthesis of qualitative studies; II – Qualitative individual studies; III – Summary of descriptive studies; IV – Individual descriptive studies individual; and V – Expert opinion[9].

Then, the results were presented and discussed in a descriptive manner. Firstly, we described the identification data of the publications (authors, year, state of origin, and institution of the study). Subsequently, the methodological characteristics of studies were evaluated and sorted according to the research design and critical evaluation of the levels of evidence[9].

In the fifth step, the evidence was grouped by similarity followed by a description of the healthcare practices that interfere in the autonomy of Brazilian women during labour and childbirth. Finally, in the sixth step, based on the discussion and interpretation of the results, we prepared the considerations of obstetric care practices and made research suggestions.

RESULTS

Regarding the quadrennial distribution of the publication frequency, the publications between 2012 and 2105 deserve special attention (Figure 2). In relation to the state of origin, there was a greater concentration in the southeastern (8 papers) and southern (7 papers) states of Brazil. It was noted that 13 studies were conducted in hospitals and 9 were conducted in outpatient treatment institutions (basic health units and delivery units). Of these studies, 15

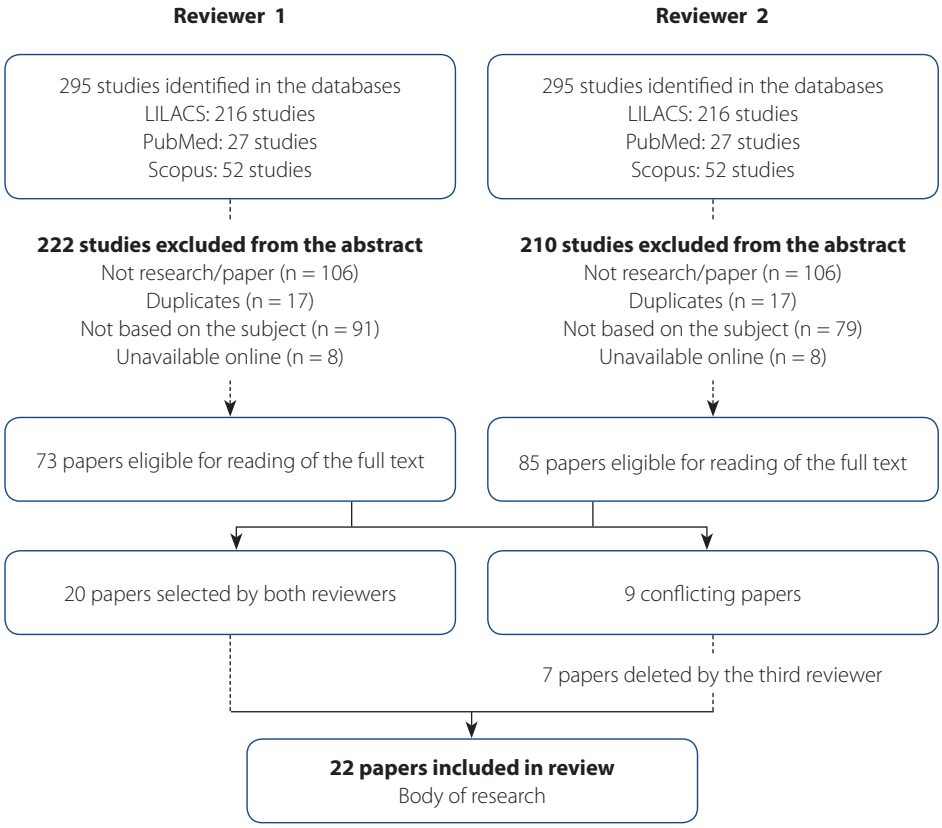

Figure 1 – Flow chart of the independent peer selection of studies surveyed in the integrative literature review. LILACS/PubMed/Scopus, 1996-2015

Source: Research data, 2016.

were conducted in one institution and 7 were conducted in several institutions.

Regarding the authors of the reviewed publications, 18 were authored by nurses only, 1 was written by a physical therapist and nurses, and 2 were written exclusively by physicians. The methodology of all the studies was qualitative research. In relation to the strength of the evidence, the 22 papers belong to the category of meaning and have level 2 evidence.

In relation to the objective of this review, the results of the papers revealed a set of healthcare practices during labour and childbirth according to the positive

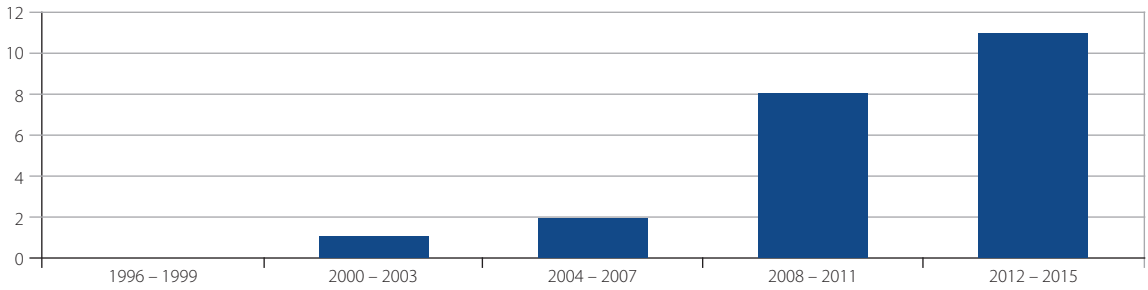

Figure 2 – Chart of the quadrennial distribution of publication frequency of scientific literature on healthcare practices that interfere in the autonomy of Brazilian women during labour and childbirth. LILACS/PubMed/Scopus, 1996-2015

Source: Research data, 2016.

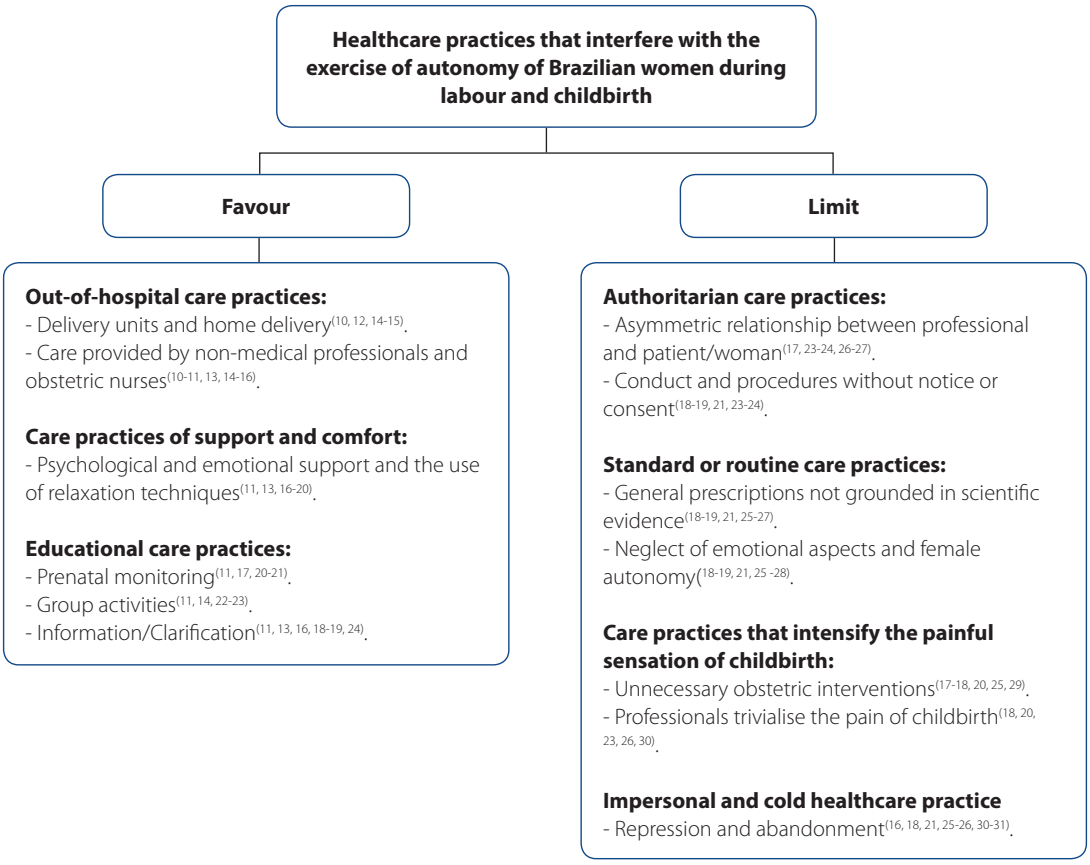

Figure 3 – Evidence of healthcare practices that interfere in the exercise of autonomy of Brazilian women during labour and childbirth. LILACS/PubMed/Scopus, 1996-2015

Source: Research data, 2016.

and negative interference of these practices in women's autonomy.

The practices that favour the exercise of autonomy of Brazilian women during labour and childbirth were out-of-hospital care practices; care practices of support and comfort; and educational care practices. The practices that limit the exercise of autonomy of Brazilian women during labour and childbirth were defined as authoritarian care practices; standard or routine care practices; practices that intensify the painful sensation of childbirth; and impersonal and cold care practices (Figure 3).

DISCUSSION

There was a low number of scientific papers related to women's health and the exercise of women's autonomy during labour and childbirth. Most of the selected studies focused on the use of good practices recommended during delivery[8], and there was a deficit of papers that addressed the subject from the perspective of this principle that is the precondition for the health and citizenship of women.

The out-of-hospital care practice was considered beneficial for the protagonism of women during childbirth[10-16]. This practice was heavily associated with the pursuit of specialised care other than the care that is provided in the traditional hospital setting, and it reflects the search for strategies to overcome the lack autonomy and fear that women feel when they have no control over the delivery process.

In this context, the delivery units and home deliveries gain momentum. Based on scientific evidence and a deep respect for the decisions of women, this practice allows out-of-hospital care that focuses on women, especially from the viewpoint of autonomy[10, 12]. Another positive aspect of the out-of-hospital setting is the possibility of non-traditional practices, such as vertical positions during delivery, that are more closely related to the active participation of parturients and assistance by non-medical professionals who believe in the potential of the female body to give birth[14-15].

Of these professionals, the obstetrics nurse or midwife favours the experience of natural and physiological childbirth that respects women's autonomy and shared decision making[11, 13-14]. The care that midwives provide is characterised by dialogue and the appreciation of women's experiences, which supports female empowerment during childbirth[10, 16].

The practices of support and comfort of these professionals also promote women's autonomy during labour and childbirth[11, 13, 16-20] since this form of care is not merely technical or procedural. Nursing professionals are considered the main facilitators of this practice, especially because they respect the feelings of women and value their complaints, provide the necessary psychological and emotional support, and apply relaxation techniques recommended by the WHO[8] to bring relief and comfort to women in labour[16, 19-20].

Educational practices are also believed to favour the exercise of women's autonomy, as supported by a large number of studies[11, 13-14, 16, 19-24]. These practices enable the development of human potential and allow the women to perceive themselves as the key subjects of their pregnancy and childbirth, which makes them active decision makers in their own care. The information obtained from the women is not only used to support their choices; it is also used to help them experience the birth of their children as they imagined it regardless of location.

Of the educational activities, the most noteworthy strategies are prenatal care and group activities. Prenatal care provides access to critical information for the autonomy of women and supports decision making related to childbirth[11, 17, 20-21]. Group activities contribute to the safety and autonomy of the couple, and generate changes in attitudes and behaviour. The educational process in groups has a positive impact on the women and on society as a whole, and could become an instrument to change the current obstetrics scenario[11, 14, 22-23].

Information essentially builds a solid basis that grants women the autonomy they need to choose or reject any procedure on their bodies, and provides support for professionals and out-of-hospital care. However, if the women are not sure of their rights or how they can claim these rights, any autonomy becomes a distant possibility. Ignorance about their own bodies and the reproductive processes merely supports the mechanisms of control and oppression assumed by these women in the hospital setting[11, 13, 16, 18-19, 24].

Contrarily, the model of technical obstetric care was directly tied to practices that restrict the autonomy of Brazilian women in the process of labour and childbirth, as described in all the studies. The basic principle of this model is authoritarian healthcare practices [14, 17-19, 21, 23-27], that is, when the professional assumes a position of authority over the user, who in this case is the woman who is expropriated from the control of her own body.

The predominant idea in this model of care is the existence of an asymmetric relationship between professional and patient[17, 23-24, 26-27], which becomes visible at the moment of delivery because, even when the women partici-

pate in the process, it is only to collaborate with the work of the professional and not to ensure the exercise of their autonomy. Since they not allowed to express their feelings or their opinions about delivery, they remain silent. Their bodies do not belong them, and even when they do speak, the health workers do not seem to listen.

This model of obstetric care includes practices that are not notified or consented[18-19, 21, 23-24]. Some procedures are usually imposed or performed without even notifying the women. The imposition of care practices is considered a violation of the woman's right to bodily integrity and freedom from abuse. When they are notified, they are not offered the opportunity to participate in the decision that involves their own bodies, which restricts and prevents the exercise of their autonomy. This lack of communication on the part of professionals somehow reveals their neglect regarding the women`s right to information.

Similarly, it was observed that the standard or routine care practices limit the exercise of autonomy of Brazilian women during labour and childbirth[18-19, 21, 23, 25-27]. It is presumed that women in labour are incapable of deciding the care they need, and they are forced to accept the discourse of the health workers. General and ungrounded prescriptions characterise a standardised and authoritarian care where women are thought to have the same bodies.

These individualised practices with no scientific basis include preparation for childbirth, sprinkler baths, hair removal, enema, prolonged fasting, infusion of oxytocin, and episiotomy at childbirth, in which the professionals are unanimous in stating that the decision cannot be made by the women who will undergo these procedures[18-19, 21, 25-27]. Similarly, in C-section deliveries, these practices include tying of the women`s hands during surgery, the use of sedatives, and the postponement of the first contact with the newborn, which only reinforces the neglect of health workers regarding the emotional aspects and autonomy of women[28].

It is acknowledged that the professionals who are present during delivery are responsible for indicating and performing certain practices since they are qualified to assess the need for interventions and prevent complications. However, standardisation or authoritative imposition and not requesting the informed consent of the women subjugates them and hinders their emancipation as an active agent of the parturition process[19, 21, 23].

It was also observed that the care practices that intensify the sensation of pain in labour negatively interfere in the autonomy of Brazilian women [17-18, 20, 23, 25-26, 29-30]. Oftentimes, these obstetrics interventions are not recommended[8], as in the case of isolation and abandonment in the obstetrics unit, the abusive use of oxytocin, Kristeller's manoeuvre, and episiotomy[18, 20, 25]. The non-use of pain relief methods and analgesia in childbirth only worsens the situation[17, 29].

The suffering caused by pain renders the women powerless, and any attempts to alleviate or minimise the pain allows women to assume control over the process of parturition and become more active and participatory. However, although pain relief techniques during labour are widely recommended, the use of these techniques varies according to the philosophy of the institution[20]. When the professional trivializes or does not consider physical complaints of the parturients, believing that the pain of childbirth is legitimate, there is no listening and no negotiating, only limitation, imposition, and violence[18, 23, 26, 30].

A cold and impersonal healthcare practice that is contrary to ministerial recommendations was also considered a barrier to the autonomy of Brazilian women during labour and childbirth[16, 18, 21, 25-26, 30-31]. It is a reflection of the loneliness, fear, and sadness caused by the abandonment in the obstetrics units. Many professionals fully transfer the responsibility of confronting labour to the women, and distance themselves by giving priority to medical prescriptions during care[16, 18, 21].

During labour, most women prefer the permanent and qualified presence of professionals, especially when they are experiencing painful contractions[18, 21]. However, when the women do not behave as expected, a heavy tension is generated among the health workers. Consequently, they adopt an attitude of disrespect for the culture of women, and repress and force the women to act according to the rules of behaviour they impose[25-26, 30-31].

Some long-standing obstetric conducts are understandably difficult to change, and discussions are needed to foster change in the current obstetric scenario[21]. It is necessary to rethink the role of health workers and the implementation of a care model that values techniques that favour human relationships to ensure individualisation, the best care, and the recovery of women`s autonomy to all those involved in the process of pregnancy and childbirth[16, 20-21].

CONCLUSIONS

This integrative literature review presented scientific literature on the healthcare practices that interfere with the active participation and decision making of Brazilian women in the process of labour and childbirth. The review showed that out-of-hospital practices, care practices of support and comfort, and educational practice positively affect the exercise of women`s autonomy. The care prac-

tices that negatively interfere with women`s autonomy are authoritarian practices, standardised or routine practices, practices that intensify the painful sensation of childbirth, and cold and impersonal healthcare practices.

A possible limitation of this review is the analysis of studies conducted in Brazil only, which prevents a general perspective of obstetric care. However, the review of Brazilian studies is justified since the models of obstetric care used worldwide differ from the models used in Brazil.

Educational practices can potentially serve as strategies to promote the role of women in the obstetric setting and ensure the exercise of their rights. However, the review also revealed a profound disconnection between routine care and ministerial recommendations, and most of the studies highlighted practices that limit the autonomy of Brazilian women in the process of labour and birth. Clearly, there is a setback in the recognition and full implementation of women's rights that prevents these women from exercising autonomy regarding their own bodies and childbirth.

The results stress the need for greater nursing intervention to ensure the autonomy of women and their active participation in the process of labour and birth. The findings also emphasise the importance of obstetric nursing in this scenario since, in addition to substantiating their care in the precepts of non-medicalisation and the appreciation of physiological birth, obstetrics nurses are growing professionally and becoming highly representative in the field of nursing in general. Therefore, future studies should address the singularities and subjectivities of women, the democratisation of relations between professionals and patients, and the perception of those involved in childbirth regarding the conceptual and ethical aspects of women's autonomy.

REFERENCES

1. Souza JP, Pileggi-Castro C. Sobre o parto e o nascer: a importância da prevenção quaternária. Cad Saude Publica. 2014;30(Supl):S11-S13.
2. Carneiro MS, Teixeira E, Silva SED, Carvalho LR, Silva BAC, Silva LFL. Dimensões da saúde materna na perspectiva das representações sociais. Rev Min Enferm. 2013 [cited 2016 sept 26];17(2): 446-453. Available at: http://www.reme.org.br/artigo/detalhes/662.
3. Silva ALS, Nascimento ER, Coelho EAC. Práticas de enfermeiras para promoção da dignificação, participação e autonomia de mulheres no parto normal. Esc Anna Nery. 2015;19(3):424-31.
4. Oladapo OT, Souza JP, Bohren MA, Tunçalp Ö, Vogel JP, Fawole B, et al. WHO Better Outcomes in Labour Difficulty (BOLD) project: innovating to improve quality of care around the time of childbirth. Reproductive Health. 2015;12:48.
5. Riscado LC, Jannotti CB, Barbosa RHS. A decisão pela via de parto no Brasil: temas e tendências na produção da saúde coletiva. Texto Contexto Enferm. 2016;25(1):e3570014.
6. Ministério da Saúde (BR). Portaria Nº 569, de 1º de junho de 2000. Institui o Programa de Humanização do Pré-natal e Nascimento, no âmbito do sistema Único de Saúde. Diário Oficial da União [da] República Federativa do Brasil. 2000 jun 8;138(110-E Seção 1):4-6.
7. Ganong LH. Integrative reviews of nursing research. Res Nurs Health. 1987 Feb;10(1):1-11.
8. Organização Mundial da Saúde (CH). Maternidade segura: assistência ao parto normal: um guia prático. Genebra; 1996.
9. Fineout-Overholt E, Stillwell SB. Asking compelling, clinical questions. In: Melnyk BM, Fineout-Overholt E. Evidence-based practice in nursing & healthcare: a guide to best practice. Philadelphia: Wolters Kluwer, Lippincott Williams & Wilkins; 2011. p. 25-39.
10. Zveiter M, Souza IEO. Solicitude constituindo o cuidado de enfermeiras obstétricas à mulher-que-dá-à-luz-na-casa-de-parto. Esc.Anna Nery. 2015;19(1):86-92.
11. Pereira ALF, Bento AD. Autonomia no parto normal na perspectiva das mulheres atendidas na casa de parto. Rev Rene. 2011;12(3):471-7.
12. Clementino MOS, Silva JV. Os significados e os motivos de dar à luz em Casa de Parto: as representações sociais no contexto bioético de puérperas de São Paulo, SP. Mundo Saúde. 2008;32(4):452-7.
13. Gonçalves R, Aguiar CA, Merighi MAB, Jesus MCP. Vivenciando o cuidado no contexto de uma casa de parto: o olhar das usuárias. Rev Esc Enferm USP. 2011;45(1):62-70.
14. Sanfelice CFO, Shimo AKK. Parto domiciliar: compreendendo os motivos dessa escolha. Texto Contexto Enferm. 2015;24(3): 875-82.
15. Gayeski ME, Brüggemann OM. Percepções de puérperas sobre a vivência de parir na posição vertical e horizontal. Rev Latino-Am Enfermagem. 2009;17(2):153-9.
16. Oliveira ASS, Rodrigues DP, Guedes MVC, Felipe GF. Percepção de mulheres sobre a vivência do trabalho de parto e parto. Rev. Rene. 2010;11(esp):32-41.
17. Melo KL, Vieira BDG, Alves VH, Rodrigues DP, Leão DCMR, Silva LA. O comportamento expresso pela parturiente durante o trabalho de parto: reflexos da assistência do pré-natal. Rev Pesqui: Cuid Fundam Online. 2014 [cited 2016 fev 19];6(3):1007-20. Available at: http://www.seer.unirio.br/index.php/cuidado-fundamental/article/view/3124.
18. Santos LM, Pereira SSC. Vivências de mulheres sobre a assistência recebida no processo parturitivo. Physis. 2012;22(1):77-97.
19. Santos JO, Shimo AKK. Prática rotineira da episiotomia refletindo a desigualdade de poder entre profissionais de saúde e mulheres. Esc. Anna Nery. 2008;12(4):645-50.
20. Pinheiro BC, Bittar CML. Expectativas, percepções e experiências sobre o parto normal: relato de um grupo de mulheres. Fractal. 2013;25(3)585-602.
21. Carvalho VF, Kerber NPC, Busanello J, Gonçalves BG, Rodrigues EF, Azambuja EP. Como os trabalhadores de um Centro Obstétrico justificam a utilização de práticas prejudiciais ao parto normal. Rev Esc Enferm USP. 2012;46(1):30-7.
22. Almeida MRCB, Souza KV, Maciel VB, Ribeiro JT, Amaro MLM, Costa MJP, et al. Percepção e perspectivas de gestantes sobre o processo do parto a partir de oficinas educativas. Rev Min Enferm. 2011;15(1):79-85.
23. Silva LM, Barbieri M, Fustinoni SM. Vivenciando a experiência da parturição em um modelo assistencial humanizado. Rev Bras Enferm. 2011;64(1):60-5.
24. Griboski RA, Guilhem D. Mulheres e profissionais de saúde: o imaginário cultural na humanização ao parto e nascimento. Texto Contexto Enferm. 2006;15(1):107-14.

25. Pimenta LF, Silva SC, Barreto CN, Ressel LB. A cultura interferindo no desejo sobre o tipo de parto. R Pesq: Cuid Fundam Online. 2014 [citado 2016 fev 19];6(3):987-97. Available at: http://www.seer.unirio.br/index.php/cuidado-fundamental/article/view/3165.
26. Nakano AMS, Ferreira CHJ, Almeida AM, Gomes FA. Childbirth experience according to a group of Brazilian primiparas. Midwifery. 2012;28(6):e844-e849.
27. Sodré TM, Lacerda RA. O processo de trabalho na assistência ao parto em Londrina-PR. Rev Esc Enferm USP. 2007;41(1):82-9.
28. Salgado HO, Niy DY, Diniz CSG. Meio grogue e com as mãos amarradas: o primeiro contato com o recém-nascido segundo mulheres que passaram por uma cesárea indesejada. J Human Growth Develop. 2013;23(2):190-7.
29. Barbosa CM, Dias MD, Silva MSS, Caricio MR, Medeiros APDS. Mulheres e parteiras tradicionais: práticas de cuidado durante o processo de parto e nascimento em domicílio. R Pesq.: Cuid Fundam Online. 2013 [citado 2016 fev 19];5(1):3206-20. Available at: http://www.seer.unirio.br/index.php/cuidado-fundamental/article/view/1893.
30. Tornquist CS. Paradoxos da humanização em uma maternidade no Brasil. Cad Saúde Pública. 2003;19(Sup.2):S419-S427.
31. Pimenta LF, Ressel LB, Stumm KE. A construção cultural do processo de parto. R Pesq.: Cuid Fundam Online. 2013 [citado 2016 fev 19];5(4):591-8. Available at: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/2344.

Corresponding author:
Thamiza Laureany da Rosa dos Reis
E-mail: thamiza1@hotmail.com

Received: 05.22.2016
Approved: 01.10.2017