DOI: 10.15253/2175-6783.20192041409
www.periodicos.ufc.br/rene

Original Article

Perceptions of nursing professionals about humanization of childbirth in a hospital environment

Percepções de profissionais de enfermagem sobre humanização do parto em ambiente hospitalar

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Objective: to understand the perceptions of nursing professionals regarding the humanization of childbirth. **Methods**: a qualitative research, developed with 20 nursing professionals from a university hospital. Data collected through a non-participant observation and semi-structured interviews, recorded audio, guided by the following question: how do you perceive the humanization of childbirth in your work context? The interviews were fully transcribed and subjected to content analysis, thematic mode. **Results**: the following categories emerged: Characteristics attributed to the humanization of childbirth and Difficulties hindering humanization of childbirth. **Conclusion**: the professionals highlighted both the actions taken that reflect on the humanization of childbirth, and also the difficulties related to the structural and resource issues, that negatively reflect on the care quality provided, besides transferring the responsibility for improving the service, which belongs to everyone, not only to managers.
Descriptors: Humanizing Delivery; Obstetric Nursing; Nursing Care; Humanization of Assistance.

Objetivo: compreender as percepções de profissionais de enfermagem quanto à humanização do parto. **Métodos:** pesquisa qualitativa, desenvolvida com 20 profissionais de enfermagem de hospital universitário. Dados coletados por meio da observação não participante e entrevista semiestruturada, áudio gravado, guiada pela questão norteadora: como você percebe a humanização do parto no contexto do seu trabalho? As entrevistas foram transcritas na íntegra e submetidas à análise de conteúdo, modalidade temática. **Resultados:** emergiram as categorias: Significados atribuídos à humanização do parto e Aspectos dificultadores da humanização do parto. **Conclusão:** os profissionais ressaltaram as ações realizadas que refletem na humanização do parto, mas destacaram as dificuldades relacionadas às questões estruturais e de recursos que refletem negativamente na qualidade da assistência prestada, além de transferirem a responsabilidade de melhoria do serviço, que é de todos, somente aos gestores.
Descritores: Parto Humanizado; Enfermagem Obstétrica; Cuidados de Enfermagem; Humanização da Assistência.

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Received: June 14th 2019; Accepted: Aug. 27th 2019.

Introduction

The humanization of childbirth is the most appropriate alternative to current biomedical and technological models to improve care for women in labor and the newborn infant, since it is a factor that favors labor and mother-child bonding[1]. In this sense, a women-centered approach with respect for rights, values, beliefs, autonomy, choices and control over their bodies and birth process are key concepts of humanized childbirth[2].

Humanized practices consist in offering pregnant women and their relatives support and information necessary for labor and delivery[3]. They include care such as: guiding the pregnant woman regarding feeding, ambulation, painful contractions and patient positioning during labor and delivery, right of having companion and choosing the delivery place[4].

Concerning to this, a study conducted with 51 mothers in a municipal hospital rooming in Fortaleza, Brazil, presented some effective care practices during labor, highlighting: the empathic support by professionals, the use of non-pharmacological methods for pain relief and freedom to choose the position during labor[5].

However, the general scenario of obstetric care is still surrounded by obstacles that hinder the implementation of humanized actions, which include access, reception, quality and resolution[4]. A study that interviewed women in the immediate postpartum period and collected information from the hospital chart found a low adherence to good practices during labor and delivery, represented, for example, by the high frequency of medication during these periods[6].

In turn, a study conducted in Tanzania showed that institutional norms and practices that prohibited family involvement during the birth process, including beliefs that limited the choice of birth position, negatively influenced the humanization of care. In addition, factors such as insufficient physical space, shortage of qualified human resources, attitudes and beliefs focused on the physician influence the quality of childbirth care. Therefore, it is necessary to overcome these barriers and provide continuing professional education so they may perform actions that contribute to integral and patient-centered care[7]. Therefore, the question was: how do nursing professionals perceive the humanization of childbirth in daily practice?

Given the above and the current scenario, in which there are still many obstacles to the implementation of humanized actions during prenatal, delivery and postpartum, it was defined as the study goal: to understand the perceptions of nursing professionals regarding the humanization of childbirth.

Methods

A qualitative study, conducted with nursing professionals from the Gynecology, Obstetrics and Surgical Center units of a university hospital in northwestern Paraná, Brazil, reference center for the monitoring of pregnant women with usual and high risk. The Gynecology and Obstetrics unit had at the time of the study, five wards, with three beds each (nine for joint accommodation, three for surgical gynecological hospitalization and three for clinical treatment of pregnant women with complications), and one room with two beds, labeled as pre-labor. The surgical center had three operating rooms and one room for vaginal delivery. Cesarean sections were realized in the operating rooms. The women in labor remained at the pre-labor unit during labor and were referred to the Surgical Center during the expulsive period.

There were five nurses at the Gynecology and Obstetrics unit (just one obstetrics specialist) and 15 nursing technicians. In the operating room, there were eight nurses and 18 technicians. The inclusion criteria adopted was to work in the respective sector for at least six months. Professionals on vacation or on leave were excluded, resulting in the participation of 20 professionals.

Data were collected from August to October 2017, through free observation and semi-structured interviews. The non-participant observation occurred

during the last stage of the author's undergraduate nursing course. The interviews took place according to the participants' availability in a private room, at the institution itself, and during work shifts, with a minimal interference to the sector's activities. They lasted an average of 25 minutes, were recorded on digital media and later fully transcribed. During them, we used a form for sociodemographic characterization and the guiding question: how do you perceive the humanization of childbirth in the workplace context? Auxiliary questions were used when further explanation and deepening of the data were required.

Qualitative data, including those from the field notes, were subjected to content analysis, thematic mode, following the three proposed steps[8]. In the pre-analysis, fluctuating and intensive readings of the data set were performed to systematize the initial ideas and survey the points relevant to the study goal. In the second stage of material exploration, the raw data were coded and systematically transformed into aggregates. Finally, in the data processing stage, the categorization was performed, with elements classification according to similarities, and by differentiation, with subsequent regrouping, according to common characteristics, with identification of two categories.

The study was developed in accordance with the guidelines of Resolution 466/2012 of the National Health Council and the project was approved by the Ethics Research Committee on Human Beings of the State University of Maringá (Opinion nº 2,230,676/2017). Participants signed the Informed Consent Form and are identified by the letters N (nurses) and T (nursing technicians), followed by a number that indicates the sequence of the interviews.

Results

Twenty nursing professionals were interviewed. Of these, ten labored in Gynecology and Obstetrics (two nurses and eight technicians) and ten in the Surgical Center (four nurses and six technicians). Nineteen were female, the participants average age was 40 years and working time in the respective units ranged from one to 26 years.

When considering the World Health Organization recommendations[9], at the curricular train ship, we observed elements that hindered the humanization of care during labor, including: Non-valuation of natural light, use of the pre-delivery room as equipment storage and reduced incentive for ambulation and experimentation of different positions during labor, which makes impossible to choose a position that would provide greater comfort and favor the evolution of labor. Also, actions that benefited the woman in labor and favored the evolution of the labor were identified, namely: guidance on stimulation activities, such as warm bathing and respect for the right to have a choice companion. Two thematic categories emerged from the analysis of the interviews, which are described below.

Characteristics attributed to the humanization of childbirth

When expressing conceptions, the participants often pointed out some structural and organizational aspects related to the service routines, such as promoters of the childbirth humanization: *Humanization is to try to make everything calmer and pleasant* (N1). *I think the less interference, the less noise, the less stress... A favorable environment, with less light, less conversation, a very calm music* (T1). *The obstetrician or resident there, and also a professional who can help the other pediatrician, who will receive the patient, that it, few people* (T13).

Also, they cited some actions with the same purpose, such as the non-medication of childbirth and restrictions of some procedures, such as episiotomy: *As humanization, I realize that it is about assisting a woman in labor in a way that labor will progress as naturally as possible, without medication, without much human interference, deliveries that occur without episiotomy, without aggression* (T5).

In addition, they pointed out the importance of providing pain relief through non-pharmacological measures and allowing skin-to-skin contact between mother and baby as early as possible: *To make massages brings a lot of comfort and relaxes. We suggest the warm bath, the exercise itself on this ball and the materials we have* (T5). Keeping the child in contact with its mother, it is very important that the

child leaves the operating room already being breastfed, having this skin-to--skin contact..., the operating room has failed a lot in this regard (T7).

It turned evident that, for the professionals surveyed, the driving force behind childbirth humanization is the relationship professional/women in labor, influenced by an individualized and empathic embracement, and dialogue directed at meeting the needs of the women: *For me, humanizing is make the women in labor to feel that at that moment we are focused on her case, doing everything to make her feel welcomed* (N5). *When a pregnant woman is admitted, then you receive her and start talking to her, knowing her context, the number of children... All of this will bring you closer to her, she will gain confidence and from that, you will start interacting much more easily, she will perform the techniques we developed for humanizing childbirth much more naturally, much more cooperatively, more spontaneously, without you being imposing* (T3). *To humanize is treating a person as you would like to be treated; is to put yourself in her shoes; call her by her name* (N4).

Another highlighted aspect of humanization was the appreciation of the right of choosing, for example, the position at the moment of childbirth: *In fact, in humanized childbirth, the recommendation is offering the women in labor the possibility to choose the position. Let her choose the position she finds the most adequate. If she wants to squat, to stand on her hands and knees, to sit on the little stool... we could advise her that, at the very end of labor, she could test these positions and see which one feels better, not imposing...* (T3). *You must respect the pregnant woman, she is the one who must decide if she likes that way or not. If she wants to squat, come on people. She is the one who has to decide, because women's rights have been discussed so much, but at the time of childbirth, some things still are prevented. I think if she wants it, it can be done* (T4).

This also involves respecting choices regarding non--pharmacological pain relief positions and measures during the course of labor: *Knowing what is the best does not mean it is going to be the faster for her. If you turn it to a must, humanization is over. So, she has the right to choose* (N6). *Look, it will be better for you, it will come down faster, it will ease the pain, it will be born faster. But I don't want to! So it's ok (N6). I want you to walk, go and use that ball. I don't want to! It will take longer, but it's her decision. That is humanizing* (N6).

Or, still, the appreciation of the right of choosing a companion: *If she chose, if it is comfortable for her, we must respect it. Because it's not for us, it's for her. We, as professionals, do not have to like or dislike that companion because it is hers (*T4). *For me, the humanization of childbirth would be having the family close* (T8).

Difficulties hindering humanization of childbirth

Institutional routine and staff sizing were referred to as hindering elements of humanization in childbirth, highlighting the limited availability of time and staff number: *Rarely you can get it, because of lack of time, of staff members. You have more urgent things to solve. So you have to choose: either you work outside (joint housing and management of the sector) or inside (pre-delivery room). Then, when possible, and you have a little time left, you come over. There is no way you can spend hours here, together and the whole time. When needed, if someone calls, then we come, if not, we don't. Only if you drop everything and stay here. But what about the rest there?* (N1).

The absence of a qualified professional to accompany labor was mentioned as a factor that negatively influences humanized care, as it limits the professional performance in providing some guidance: *We take care of several other patients. So many times, she stays here with a relative, and when not, she stays alone. Therefore there is not a doula that guides and so. We give the first instructions, but not always there is someone here watching. So, I think our birth is not humanized. In my opinion, it is not* (T9).

During the curricular internship, it was observed that women in labor did not always receive the recommended care. This is because, despite believing in the importance of humanizing childbirth, they prioritized other activities, including the days and times when the unit was under-occupied by patients, as identified in field notes: *I see that the patient remains alone for a long time in the pre-delivery period, both in the morning and at night. It was calm, the professionals could have assisted her and given the guidance, talked to her, especially when she was crying in pain. I think this presence is missing. At least during the hours I was there, nobody came to know how the patient was and the staff was, to some extent, available. They could have gone in there and paid attention to the pregnant woman and the relative* (Field note).

The employees of Gynecology and Obstetrics stressed that to reverse this situation there is a need for an exclusive professional staff to ensure humanized assistance to women in labor: *... It would require a specific technician per period. When a pregnant woman in labor is admitted, he or she will be only there in the delivery room, giving this assistance all the time* (T3).

Regarding feeding, there was a divergence of opinions. While in Gynecology and Obstetrics the feeding of the patient in labor was released, the professionals of the Surgi-

cal Center were opposed to this routine, believing that this could cause complications to the women in labor: *I say while she is in the operating room, when into labor, she has to be fasting. If a problem arises, then you must have a cesarean, so there is risk of vomiting and complications. Even if it is a vaginal delivery, because it can present complications. I think at least six hours the mother has to hold on. No water and no food. I think the patient who is in labor is not hungry, it is not possible. She gets those horrible pains, because it's horrible* (T11).

Regarding the labor and delivery position, professionals recognized that, in the institution studied, the conduct taken was anti-humanization: *She does what she is oriented to do, nobody says: look, you choose the way you want and we will welcome your baby at birth.. I never heard anyone saying that. She arrives and is immediately positioned in the gynecological position, she has no idea that there is another types of positions because the professional is the one who must instruct her, if he is not willing to guide and do differently, it will not be done differently* (T1). *They don't encourage another position. It is always the same* (T14). *How can we humanize birth here? It's complicated, who is going to stand up to these doctors* (T6).

In addition, some professionals reported believing that this position would be ideal: *It is the most appropriate and comfortable* (T14). During the internship, it was observed that the gynecological position adopted at all times was not the most comfortable, according to the recorded impression: The patient kept slipping all the time. *As she strained, she began to slip. It seemed as she would fall at any moment. Then the nurse went behind the table and pull the mattress up so the patient in labor wouldn't fall off the table. So, apparently, the place and positioning were pretty bad. The uncomfortable table and the pregnant woman under pain with each contraction. A very bad position, a very bad table, where she kept slipping all the time* (Field note).

Participants assumed that the fact of being a teaching hospital made it impossible to fully humanize care, and there was even compliance with the situation: *Here, she has no privacy, there is no way to have privacy in a teaching hospital. Because it may enter the obstetrician, the resident, the interns, the students, the husband, sometimes the nursing technicians, has no privacy, there is no way to have privacy. Sometimes you arrive at a delivery room and have about 10 people* (T14).

The professionals from both sectors justified the absence of actions aimed at humanizing childbirth by the lack of an obstetric center: *No, here, in the Gynecology and Obstetrics sector... there should be an obstetric center there, linked to the operating room, he said. If there is an emergency, if something is needed for the baby, everything is there, there is a doctor present, anesthesiologist, if it needed, so I think the assistance there would be better* (N1). *Ideally, you should have an obstetric center where you wouldn't just come here to get the baby. Let her stay there, already in a prepared environment. I've been in hospitals that have an obstetric center, doing internship, doing follow-up. That is something quite different. The woman is already admitted at the obstetric center and the whole process happens there... They are able to say: Ah, I have a more humanized care* (N3).

And yet, some professionals pointed out that the humanization of childbirth will only truly occur if the actions are initiated since prenatal care: *It must start since there. Things have to start from a foundation, including humanization. Adopting it at the beginning, and then continuing onwards* (T5).

They pointed out as a deficiency in this care sphere the unpreparedness of the relative companion who often does not know his own role: *I think that, to be successful, you should start there at the health center, the prenatal care. Because not everyone gets here prepared. It is difficult that an instructed companion may come. They give us hard work. The majority does. A ten percent help, but most get in the way* (T9). *They must realize that their focus is not taking pictures, but following, giving support. So, it should start in prenatal care* (N4).

The lack of adherence of professionals and the attitudes of managers were also perceived as difficulties: *I think that political will is lacking. You know? There is still a lack of willingness on the part of the hospital heads: Let's do it this way! From now on it will be like this* (N5)! *Because we have great professionals who are focused on humanization, those who are not, will come here, find many excuses and will perform a cesarean section. They will do all that causes iatrogenic damage: break the amniotic sac, administer oxytocin. Therefore, as long as it doesn't come from the supervision, the hospital heads: Let's do as many workshops as you want, but we'll be stay like this! It will not happen* (N6).

Discussion

The study was conducted in a teaching hospital, which could influence the knowledge of the professional staff regarding the issues recommended by current policies. In addition, the institution had a physical structure that was not entirely consistent with the policy of humanization, as, for example, it had no pre-delivery, delivery and postpartum room. Thus, it is pointed out as limitation the interference of these factors in the perceptions of the researched professionals about humanization and the possibility

of having made reference to what is advocated and not necessarily to the practice experienced in the work context. In any case, the results provide subsidies for professionals to they may reflect on daily practice and implement care actions based on the principles of humanization.

In the category Characteristics attributed to the humanization of childbirth, it was observed that, for some participants who made statements, humanizing childbirth care involves providing the woman with a warm, pleasant and cozy environment, characterized by darkness and absence of noise. This perception corroborates what is established by the National Humanization Policy and the Stork Network, which highlights, for example, the importance of a warm and comfortable environment, with control of lighting and noise[1].

In this sense, it importance to stress the need for professionals to have knowledge about the actions that favor the adequacy of the environment and the attendance to the women in labor. The World Health Organization makes recommendations and proposes approaches to reduce unnecessary medical interventions, as essential to humanization[9]. Among these, it is highlighted the necessary care during labor, delivery and immediate postpartum for both the mother and the newborn; the choice of companion during labor and birth; respect and good communication between patients and the professional staff; the preservation of privacy; the freedom of choosing the position during labor and delivery; and non-pharmacological measures for pain relief[9].

Another point highlighted by the World Health Organization is the respect to the rate of cervical dilation during active labor, which cannot be standardized because it is inaccurate in the occurrence of dystocia during delivery and that a slower rate of dilation should not be reason for accelerating childbirth[9]. Therefore, the behavior of accelerating the labor process induces the professional to unnecessary interventions, making the experience of giving birth unpleasant, in addition to harming the natural birth event[8].

They also cited some actions with the same purpose, such as the non-medication of childbirth and procedure restrictions, such as episiotomy. A study conducted with nurses in an obstetric center in southern Brazil found that they considered essential, that interventional obstetric practices should be avoided and recommended the adoption of non-pharmacological pain relief techniques to provide humane care at delivery. For the ones who participate on this research, the assistance based on invasive procedures, in addition to dequalificate the vaginal delivery, makes the women in labor stop being a protagonist of this process, transferring this role to professionals[10]. Similarly, in the present study, the participants highlighted the importance of non-pharmacological practices for the humanization of care and gave special emphasis to the non-medication of childbirth and restriction of some procedures, such as episiotomy.

It was observed that, in the conception of the investigated professionals, encouraging and providing skin-to-skin contact between mother and baby and promoting breastfeeding soon after birth, also characterize actions that favor the humanization of childbirth and bonding formation between mother and child from the first minute of life. It is emphasized that the first few minutes after birth is a "sensitive period" for setting future physiology and behavior, as well as representing a higher probability of successful exclusive breastfeeding[11], as directed by the National Guidelines on Assistance for Normal Birth[12] and recommended in national and international studies[1-2,7,9].

The empathic relationship between professional and patient in labor was also mentioned as a contributor to the humanization of childbirth, corroborating the results of other studies, such as one performed with nurses from a teaching hospital inside the country, which highlighted the welcoming, the individuality of each patient, the dialogue and the empathy as resources that humanize childbirth[10]. A review

of theses and dissertations on the theme[13] also identified interpersonal relationships as characteristics of humanized care. Thus, welcoming contributes to a good relationship between those involved and avoids stressful situations for women, besides allowing the professional to show attention and availability to understand expectations and clarify doubts[10].

The patient's right of choosing a companion and the freedom to pick the position perceived as more comfortable during labor and delivery were also pointed as humanization practices. However, this concept was not unanimous among professionals, as some highlighted the need for relatives to be prepared to recognize their role in this context. This thinking is different from the results obtained in a research with nursing professionals at the Luzia Women's Mother Hospital in Macapá, Amapá, Brazil, who recognized that if the patient chooses its companion, it benefits the childbirth process[14].

Thus, it is highlighted the importance of health professionals to provide opportunities and encore the search for guarantee of the patient rights related to the companion - a legally supported action that positively influences the humanization of childbirth. A research with maternity nurses in Rio de Janeiro, Brazil, showed that they consider essential for the humanization of childbirth that professionals recognize, respect and contribute to the patient awareness and autonomy in the exercise of her rights[15].

In turn, regarding the category Difficulties hindering humanization, professional overload was mentioned by Gynecology and Obstetrics nurses as one of the main difficulties to perform humanized care, because, besides attending women in labor, the sector demands involve the care of postpartum patients, their children and gynecological surgical hospitalized patients, making it clear, that care for women in labor is not prioritized.

The workload of nursing professionals is a reality and this may affect the care quality, the relationship with the staff and users. A research on the psychological workload of nurses who labor in maternity hospitals inside the country shows, that nurses have difficulty in reconciling administrative and care activities, which reduces the performance in direct care, as the demands that emerge in the work environment to effect care, fall on it, limiting the time that could be devoted to the patient[16].

According to this, the professionals highlighted the need to rethink the distribution and organization of human resources, and even the growth of the professionals working in this sector, so that may be professionals to provide exclusive assistance to the women in labor, such as doula or another professional of the staff, with specific assignment and duly qualified to do so. Nurses from a maternity unit affiliated to the Unified Health System in Piracicaba, São Paulo, Brazil, pointed out the benefits of the presence of a doula, especially regarding the physical and emotional support offered to the woman in labor, besides providing information during labor and delivery, which contribute to the reduction of pharmacological measures and caesarean sections, plus providing women with greater safety, confidence and satisfaction regarding the experience of childbirth[17].

Still, among the practices that hinder the humanization of childbirth, we highlight those related to medical behavior, which corroborates the findings of another study with nursing professionals[18]. These results show that the decisions and faculties that physicians have over childbirth care still stand out, that means, in many places, even in the hospital of the present study, nursing professionals did not have autonomy in the assistance to labor and delivery.

The positioning indicated by professionals at childbirth was clearly perceived as one of the institutional routine elements that most impedes to the realization of humanized care. A study conducted in an obstetric center of a teaching hospital in the city of Pelotas, Rio Grande do Sul, Brazil, also found that the only delivery position allowed by professionals was the lithotomy one[19]. Therefore, it is necessary to develop actions along with the staff that promote awareness about the benefits of valuing, when possible, the

patient choices, including the position for childbirth.

Sometimes, the negligence in promoting the patient privacy was pointed out as one of the elements that occurs daily in the institution and that negatively influences the humanization of the care provided. This behavior was also signaled in a study with maternity nurses from Piracicaba, São Paulo, Brazil, who recognized the lack of privacy for pregnant women admitted to the service[17]. Thus, there is an urgent need to plan actions that reverse this dehumanization and ensure the women privacy, allowing them to make this moment something special, make choices and, whenever possible, respect the patient's principles and beliefs[20].

With a view to the effective qualification and humanization of childbirth, the professionals also highlighted the need for involvement of the hospital management team in the planning and implementation of practices aimed at humanization. Thus, providing discussions among professionals who participate directly in care and management, favors the development of different strategies that promote humanized care[10].

Conclusion

According to the researched nursing professionals, the humanization of childbirth has meanings that encompass structural and organizational aspects of the institution; the relationship professional/women in labor, the respect for women's autonomy and the right of choosing. They recognized that simple attitudes and care measures, such as empathy, feeding, and enlightenment, are good practices for humanized childbirth and are viable in the workplace, as they do not depend on technology or large infrastructure investments. In turn, they pointed as critical aspects, some directly related to the institutional routine and shortage of qualified professionals for exclusive attention to the women during labor, as well as the absence of an obstetric center.

Collaborations

Ferreira MC collaborated with conception, design, analysis, interpretation of data and article redaction. Monteschio LVC and Oliveira L collaborated with the article redaction and final approval of the version to be published. Teston EF, Serafim D and Marcon SS contributed to the article redaction, relevant critical review of the intellectual content and approval of the final version to be published.

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