

**BROADENING GLANCES AND PRACTICES: LISTENING TO WOMEN
ATTENDED AT A NATURAL BIRTH CENTER****AMPLIANDO OLHARES E PRÁTICAS: ESCUTA ÀS MULHERES ATENDIDAS
EM UM CENTRO DE PARTO NORMAL****AMPLIANDO LAS MIRADAS Y PRÁCTICAS: ESCUCHANDO A LAS MUJERES
ASISTIDAS EN UN CENTRO DE PARTO NORMAL**

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Funding source: Authors.

Manuscript binding: Residency Final Term Paper in Obstetric Nursing at the Instituto de Medicina Integral Professor Fernando Figueira (IMIP).

How to cite this article: Araujo MRA, Pelizzoli FCS, Araújo VM. Broadening glances and practices: listening to women attended at a normal birth center. Rev Enferm Atenção Saúde [Internet]. 2021 [access: ____]; 10(3):e202130. doi: <https://doi.org/10.18554/reas.v10i3.4649>

ABSTRACT

Objective: To analyze the perception of women who received assistance at the Normal Birth Center of the Professor Fernando Figueira Institute of Integral Medicine. **Method:** It followed a descriptive exploratory design, of qualitative approach. Accomplished at Normal Birth Center, located in the city of Recife - PE, with 18 postpartum women. The participant observation technique was used and semi-structured interviews, analyzed using the content analysis technique. **Results:** A healthy and welcoming space was observed, entitled to companion throughout the period. The most births occurred without any intervention, especially non-pharmacological pain relief methods. In the period after birth, respect for the 'golden hour' was reported, in order to minimize the separation between mother and baby. **Conclusion:** The satisfaction with the care received was the predominant feeling, technical and human care follow the good practices of childbirth care.

Descriptors: Maternal-Child Health Services; Humanizing delivery; Patient Satisfaction; Nurse Midwives.

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RESUMO

Objetivo: Analisar a percepção das mulheres sobre a assistência que receberam no Centro de Parto Normal do Instituto de Medicina Integral Professor Fernando Figueira. **Método:** Trata-se de uma pesquisa descritiva e exploratória, com abordagem qualitativa. Realizada em um Centro de Parto Normal do Recife - Pernambuco, com 18 puérperas. Utilizou-se a técnica de observação participante e entrevistas semiestruturadas, analisadas a partir da técnica de análise de conteúdo. **Resultados:** Observou-se um espaço saudável e acolhedor, com direito a acompanhante durante todo o período. A maioria dos partos ocorreu sem nenhuma intervenção, com destaque para os métodos não farmacológicos de alívio da dor. No período após o nascimento foi relatado o respeito à 'hora dourada', no sentido de minimizar a separação entre mãe e bebê. **Conclusão:** A satisfação com a assistência de enfermagem foi o sentimento que predominou, os cuidados técnicos e humanos seguem as boas práticas de atenção ao parto. **Descritores:** Serviços de Saúde Materno-Infantil; Parto Humanizado; Satisfação do Paciente; Enfermeiras Obstétricas.

RESUMEN

Objetivo: Analizar la percepción que tienen las mujeres sobre la asistencia que recibieron en el Centro de Parto Normal del Instituto de Medicina Integral Profesor Fernando Figueira. **Método:** Investigación descriptiva y exploratoria, con un enfoque cualitativo. Realizada en un Centro de Parto Normal en Recife - Pernambuco, con 18 puérperas. Se utilizó la técnica de observación participante y entrevistas semiestructuradas, analizadas a partir de la técnica de análisis de contenido. **Resultados:** Se observó un espacio saludable y acogedor, con derecho a un acompañante durante todo el período. La mayoría de los partos ocurrieron sin ninguna intervención, priorizando los métodos no farmacológicos para aliviar el dolor. En el período posterior al nacimiento, se informó el respeto por la 'hora dorada', para minimizar la separación entre la madre y el bebé. **Conclusión:** Predominó la satisfacción con la atención de enfermería, los cuidados técnicos y humanos siguen las buenas prácticas para la atención al parto. **Descritores:** Servicios de Salud Materno Infantil; Parto Humanizado; Satisfacción del Paciente; Enfermeras Obstetras.

INTRODUCTION

The displacement of female care by the medical power and the institutionalization of childbirth in hospitals, inscribed pregnancy in the logic of the pathology, there was an overestimation of risks and an underestimation of the woman's ability to give birth without needing all the technological apparatus.¹⁻² In addition, the woman started to be disregarded as an active and conscious subject, free to gestate and give birth according to her desires,

contributing to gender domination relationships.¹

In the mid-1980s, with the expansion of feminist groups, the issue of women's health gained space and importance in Brazil.² Faced with a context strongly marked by the so-called cesarean section epidemic, the understanding of childbirth as an integral theme of the reproductive rights agenda was developed, the feminist movement denounced obstetric violence and the absence of female protagonism.¹ There was an approximation of the

humanized approach, fighting for the revaluation of the sexual, social and spiritual dimensions of birth.²

The Ministry of Health (MH), from the 90's, published ordinances in favor of the humanization of childbirth care. In 1999, it established the Normal Birth Center (NBC) within the scope of the Unified Health System (SUS), and in 2015 it redefined the guidelines for its implementation and qualification in accordance with the 'labor and birth' component of the Rede Cegonha. Inserted in this care network, the NBC aims to promote the humanization and quality of care for women in normal delivery without dystocia, which can function physically integrated or isolated from the hospital, and which obstetric nurses make up the minimum team.³

Although the NBC was created more than twenty years ago, there are a small number of units in Brazil, perhaps a reflection of the hegemony of medicalized and hospital childbirth, in addition to the conflicts arising from the technical and social division.⁴ The assistance in this place considers childbirth a physiological process and obstetric nurses are among the most appropriate professionals for its follow-up, contributing to its natural evolution due to the less interventionist characteristics of care.⁵ Quality care for women in labor is a fundamental right and represents an

indispensable step to ensure that she can exercise a voluntary, pleasurable, safe and socially supported motherhood.²

However, there is a scarcity of data on the quality of care at NBCs, from the perspective of the women attended.⁴ The users' perception reflects the different moments of care, as well as the way in which care is given or received. In this way, knowing through the users the reality of this model of obstetric care in an institution in the northeast of Brazil, makes it possible to expand a more respectful and humanized care strategy. Therefore, the guiding question of this study was: 'What is the perception of women about the assistance they received at the NBC of the Instituto de Medicina Integral Professor Fernando Figueira (IMIP)?'. The objective was to analyze the perception of women about the assistance they received at the IMIP NBC.

METHODS

This is a descriptive and exploratory study, with a qualitative approach, which delves into the world of the meanings of human actions and relationships, phenomena that cannot be reduced to equations, averages and statistics.⁶ The scenario was the IMIP, located in the city of Recife - PE, a philanthropic institution linked to the SUS and which has a tradition in the care of high-risk pregnant women.

More specifically, the research was developed at the NBC, which was reformulated in a new space in July 2018 to serve women at usual risk. Classified as type II, as it is located within the hospital's internal facilities, it has five beds and provides pre-delivery, childbirth and post-delivery care (PPP). The assistance is developed on site by a team composed of obstetric nurses and nursing technicians.

The study population were women in the immediate postpartum period, attended at the IMIP NBC during labor and delivery, and aged 18 years or older. Women who had any complications during childbirth and needed more care were excluded. The sample was random, delimited by the criterion of data saturation, defined as the suspension of inclusion of new participants when the data obtained begin to present, in the researchers' assessment, some redundancy or repetition.⁷ From this, 18 participants were selected.

Data collection was carried out in February 2019, through participant observation with field diary recording and semi-structured interviews with audio recording. As previously mentioned, the guiding question was: 'What is the perception of women about the assistance they received at the IMIP CPN?'. The topics investigated included: reception by the institution, perception of the physical space, permission of a companion, treatment

received by professionals, procedures performed and satisfaction with the assistance. The interviews were carried out within the first 48 hours after delivery, in the private room where the patient was accommodated.

After being transcribed, the interviews were submitted to content analysis proposed by Bardin, which is equivalent to a set of communication analysis techniques and is organized around three chronological poles: 1) the pre-analysis, where the so called 'floating' reading; 2) encoding, which is the process by which raw data are transformed; 3) treatment of the results, a stage in which data interpretation also takes place.⁸ From this analysis, three categories emerged, elaborated by the criterion of relevance based on the objective and on the scientific literature guiding the study.

It is noteworthy that data collection was initiated only after approval by the Research Ethics Committee of the IMIP, opinion 3,077,874; observing the recommendations of Resolution No. 466/2012 of the National Health Council (CNS), which deals with research involving human beings.⁹ All participants, after receiving the appropriate information relevant to the study along with the Free and Informed Consent Form (ICF), voluntarily agreed to participate in the interview. Aiming at anonymity and in honor of Dona

Prazeres (nurse and midwife, Heritage Living of Pernambuco), the participants were coded by the name 'Prazeres', followed by a number to represent the order of participation.

RESULTS AND DISCUSSION

The profile of the 18 women who participated in the study is detailed in Table

Table 1. Sociodemographic characteristics of puerperal women assisted at the Normal Birth Center of the Instituto de Medicina Integral Professor Fernando Figueira. Recife, 2021.

Characteristics	No	%
Race/color		
Brown	16	88.9
White	02	11.1
Marital status		
Stable union	15	83.3
Married	02	11.1
Single	01	5.6
Education (level)		
Incomplete fundamental	05	27.7
Incomplete high school	04	22.2
Complete medium	07	38.9
Incomplete higher	01	5.6
Complete post-graduation	01	5.6
Occupation		
Housewife	12	66.7
Information technology analyst	01	5.6
Autonomous	01	5.6
Clerk	01	5.6
Hairdresser	01	5.6
Student	01	5.6
Fish seller	01	5.6

Source: Authors, 2021.

Good practices during labor and delivery

When hospitalized, the pregnant woman is referred to the NBC and the first aspect that draws attention is the ambience, which represents a space planned according to the needs of users and workers – healthy, welcoming and comfortable.¹⁰ There are five private suites, named after flowers to identify them, they have a PPP bedroom and a bathroom with a hot shower, one of which

1. The age ranged from 19 to 35 years, with a mean of 25 years (standard deviation \pm 4.9). Most self-declared mixed race/color (88.9%), had completed high school (38.9%) and were housewives (66.7%) (Table 1). In addition, the mean parity was two children (standard deviation \pm 1) and four women were primiparous.

also has a bathtub. All the women interviewed rated the place as ideal for experiencing labor and birth, factors such as hygiene, silence and privacy were observed, narrated as follows:

I thought it was good, I thought it would be a room full of people, all that agony that we see, right, but it was good (Prazeres 9).

I was feeling confident even because of the environment I was in [...] Everything is clean,

everything is calm, everything is well organized, nothing is left out (Prazeres 1).

I had privacy in everything, because they warn me about everything, ask permission, I felt good, really good (Prazeres 18).

Adequate space also favors the internal policy that allows, during labor and delivery, the presence of two companions of the patient's free choice and one more doula. The participants' choices regarding their companions varied between the mother, mother-in-law, friends and the partner. Recognized benefits were mainly in the emotional aspect, which favors the comfort and encouragement of women, minimizing anxiety and stress. A study carried out in a NBC in Piauí presented similar findings.¹¹

Ah, when the person has a person known to the person, right, the person suffers, but knowing that there is that person right next door helping (Prazeres 13).

I strongly recommend a doula to everyone, because as you don't know much about the process, there were times when you were so tired that you thought you couldn't take it anymore, you know, and she gave moral and physical support, a lot for me and my husband also (Prazeres 12).

As highlighted in the speech above, in addition to her husband as a companion, a parturient had the assistance of a private doula. The only one to experience this specific care, since the maternity hospital does not have a program for voluntary doulas. The doula is considered a woman with the knowledge and skill to provide physical (massage, exercise, breathing

assistance) and emotional support (calming, encouraging, providing informational support). This partnership in care can increase patient satisfaction; therefore, it is necessary to move forward with the discussion, so that the role of the doula is recognized and validated.¹²

Support from staff outside the hospital team does not dispense with the support offered by nurses. The recommendations emphasize, in addition to support, non-invasive and non-pharmacological methods of pain relief in childbirth.¹³ Among the main practices, massage, aspersion bath and aromatherapy were observed. In addition, they were encouraged to move and adopt more vertical positions that were comfortable for them, as the women put it:

The nurse gave me a massage, I took a hot bath [...] (Prazeres 4).

I walked, I went to the ball, I exercised in the thing that is there, squatting (Prazeres 7).

They showed the best position for the baby to come down, for me too, it was great (Prazeres 14).

Vertical postures and maternal mobility during the first stage of labor can improve its progress and promote better maternal and neonatal outcomes.¹⁴ In view of this, pregnant women must have access to evidence-based information, to encourage their autonomy in decision making. As in the following report, even when they choose to stay in bed, they must be respected:

I was free to stay in the position I wanted, which they left me lying down. They didn't say 'you have to get up to walk, sit on the ball'. I stayed in bed and they let me (Prazeres 15).

Likewise, the parturient's desire to eat and drink during labor was considered, Prazeres 6 comments: *In labor I was eating, I even had lunch.* Prazeres 17 reports that: *No eating, I was vomiting and drinking a lot of water.* The HM recommends the ingestion of liquids, preferably isotonic solutions instead of just water, and a light diet.¹³

The participants' narrative suggests that, in general, technical care follows good practices in childbirth care. Resolution No. 36/2008, which provides for the technical regulation for the operation of obstetric and neonatal care services, guides the following care operational processes: performing intermittent fetal auscultation; control of the parturient vital signs; evaluation of uterine dynamics; the height of presentation, the variety of position, the state of the membranes, the characteristics of the amniotic fluid, dilation and cervical effacement, with a record of this evolution in partogram.¹⁵ As we can see in the speech of Prazeres 8: *The touches were at most every four hours that they gave and listening to the heart had the right time that they listened. [...] Then they would listen, see the pressure, put the thermometer, everything very well.*

There was divergence in relation to the sensation of each woman in the face of obstetric procedures, some did not perceive

any kind of discomfort, while others reported pain and discomfort. Citing the vaginal examination, which is recommended at intervals of every four hours¹⁶, there were still those who showed strangeness in the face of the restriction in the frequency and total number of exams:

I asked her to touch, she said 'no, here we touch only the last ones' (Prazeres 6).

In the total number of deliveries, 12 were described without any intervention; three women underwent artificial rupture of the amniotic membrane, one used oxytocin infusion and two received both interventions, used for what is called 'active management', with the aim of accelerating labor. As demonstrated in the excerpts from the interviews below:

Because when I started I was five (centimeters dilated), but the problem was that after my contractions stopped, they didn't come any more. I had to take a serum to see if I could get the contractions back, then my water ended up bursting and that's when I managed to have it (Prazeres 7).
They asked if I wanted it (amniotomy), then I said I wanted to speed it up (Prazeres 2).

A systematic review found a modest reduction in the number of cesarean sections when active management of labor is practiced, compared with expectant management. However, the benefits of this small reduction must be weighed against the risks of interventions in women at usual risk.¹⁷

Humanization of birth and postpartum care

The National Guidelines for Assistance to Normal Childbirth, call attention to the period immediately after birth as a very sensitive moment, and that assistance should be aimed at minimizing the separation between mother and child.¹³

Among the reports, one can see the fulfillment of the 'golden hour' through skin-to-skin contact between mother and baby immediately after birth for at least one hour; delayed clamping of the umbilical cord; encouraging the mother to recognize when the baby is ready for breastfeeding, offering help if necessary¹⁶:

They put her in contact with me right away and already told me to breastfeed too (Prazeres 7).

She breastfed for almost a full hour, I think this is unique, something you don't see in other types of delivery, right. [...] We only cut the cord after the placenta came out, including my husband who cut it. So we waited for the placenta to come out then cut the umbilical cord, they asked if I wanted to do something with the cord, if I want to do something with the placenta (Prazeres 12).

It was also observed that the team valued the subjective aspects involved at the moment, such as the opportunity for the companion to cut the umbilical cord. As for some women, contact with the placenta emerged in several meanings, overcoming the biomedical construction of clinical residue. Although not a uniform practice across all shifts, the placenta stamp (made as a print on a canvas) proved to be a

powerful symbol of motherhood, birth and life.

I saw it, I took my placenta, the placenta was on top of me, I took a picture, it was stamped, there is my stamp of her placenta (Prazeres 1).

I asked to paint it (placenta) to save it, but it took so long, it took, it took and ended up doing nothing (Prazeres 5).

In this scenario, the only intervention that marked the immediate postpartum period for seven of the ¹¹ women who had a perineal tear was suturing for repair. The NBC values the zero rate of episiotomy, since there is no evidence to support the need for its routine or liberal use¹⁶, but based on the reports, a significant percentage of spontaneous lacerations is assumed. The Cochrane Data base of Systematic Reviews conducted a review to assess the effect of perineal techniques during the second stage of labor on the incidence of perineal trauma, suggesting that warm compresses and massage may reduce third- and fourth-degree injuries, but the impact of these techniques on other outcomes was not clear.

She went to see if stitches were needed, then she gave anesthesia and it was uncomfortable, she had to give anesthesia from moment to moment because it was hurting (Prazeres 5).

There was a laceration, I think that's what it's called. Then it bothered me a lot [...] I was already without strength for anything (Prazeres 4).

Satisfaction with the assistance and recognition of nurses

Satisfaction with the assistance received was the feeling that predominated among the participants of this research, in the set of technical and human factors involved. The interpersonal relationship was highlighted as an important factor for the promotion of humanization, as the women felt welcomed and supported, resulting in greater confidence and security in labor and delivery.¹² Here are some examples:

I feel that there is still a lot of obstetric violence out there [...] I've heard a lot of reports. But not here, so I wanted all women to be able to go through the same experience I had, because it was great (Prazeres 1).

When my companion had to go down for lunch, she (nurse) came and stayed with me talking in the room, when I felt the pain, she gave me a massage. So it was good, it gave me confidence, I liked that part, it was different (Prazeres 8).

Wonderful, just gratitude, there's nothing to say about the girls. It really helps, massages, talks and I'm looking for a place where there are people like that who work with love (Prazeres 16).

The speeches suggest a bond between user and professional, but a confounding factor was the imprecision regarding the name and professional category of the person responsible for the delivery. One woman had no recollection of identifying the professionals, another stated that they did not introduce themselves, three reported presenting only the name and 13 said they were informed of the professional's name

and category - among the latter, most did not remember the presentation data. Being recurrent in the speech of the participants, the identification of the person responsible for childbirth care as a doctor, even though the team consists exclusively of obstetric nurses and nursing technicians:

(Do you know what the profession of the person who assisted you is?) Nurse, I think the boss too, doctor too (Prazeres 14).

I don't remember the name, but it was two interns and two doctors (Prazeres 5).

Everyone who came in introduced themselves and talked. But the person in pain is not paying much attention (Prazeres 8).

Even with the presentation from the name, its insertion in the team and what it is up to it to perform, the non-recognition of nursing by the women interviewed is revealed. The challenges emerge through a constellation of powers, showing that the task is complex. It is a tense movement, of investing against the established order, in the direction of a woman-centered and demedicalized model.²⁰

CONCLUSIONS

In short, the NBC was positively evaluated through maternal reports, confirming the premise that the environment and good care practices interfere with the quality of childbirth care. The care provided by the obstetrician nurse stood out for its support and continuous monitoring during labor and delivery, with

the use of non-invasive technologies and respect for women. It is expected to make visible the importance of this profession for the reconfiguration of the care scenario, through an autonomous and qualified action. In this sense, it is also essential to strengthen the SUS and public policies on maternal and child health, including fostering the construction of new NBCs.

The movement for the humanization of childbirth and birth includes different actors; here the central role of women in this process was rescued. The perception of the women interviewed raised relevant information, which should be considered by health professionals, to improve the quality of care. Therefore, the most effective care is focused on parturient needs, guided by sexual and reproductive rights, and based on scientific evidence.

This study was limited to only one NBC that has its contextual specificities; however, similar results can be found in other places that follow the guidelines defined by the MH. Another limitation was the investigation of the meanings attributed to obstetric care only by postpartum women, without exploring the perspective of other actors involved in this process, such as family members and nurses. Even so, this work advances in the construction of a little explored knowledge in the maternal and child scenario, highlighting the contribution of obstetric nursing.

REFERENCES

1. Pimentel C, Rodrigues L, Müller E, Portella M. Autonomia, risco e sexualidade: a humanização do parto como possibilidade de redefinições descoloniais acerca da noção de sujeito. REALIS [Internet]. jan/jun 2014 [citado em 20 dez 2021]; 4(1):166-85. Disponível em: <https://periodicos.ufpe.br/revistas/realis/article/view/8813/8788>
2. Rede Nacional Feminista de Saúde, Direitos Sexuais e Direitos Reprodutivos. Dossiê humanização do parto [Internet]. São Paulo: Rede Nacional Feminista de Saúde; 2002 [citado em 25 maio 2019]. 40 p. Disponível em: https://redesaude.org.br/wp-content/uploads/2021/01/Dossie_Humanizacao-do-parto.pdf
3. Ministério da Saúde (Brasil). Portaria nº 11, de 7 de janeiro de 2015. Redefine as diretrizes para implantação e habilitação de Centro de Parto Normal (CPN), no âmbito do Sistema Único de Saúde (SUS) para o atendimento à mulher e ao recém-nascido no momento do parto e do nascimento, em conformidade com o Componente PARTO E NASCIMENTO da Rede Cegonha, e dispõe sobre os respectivos incentivos financeiros de investimento, custeio e custeio mensal [Internet]. Brasília, DF: Ministério da Saúde; 2015 [citado em 20 dez 2021]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2015/prt0011_07_01_2015.html
4. Garcia LV, Teles JM, Bonilha ALL. O centro de parto normal e sua contribuição para atenção obstétrica e neonatal no Brasil. Revista Eletrônica Acervo Saúde [Internet]. 2017 [citado em 20 dez 2021]; (Supl 7):356-63. Disponível em: <https://acervomais.com.br/index.php/saude/article/view/8278/4995>
5. Santana AT, Felzemburgh RDM, Couto TM, Pereira LP. Atuação de enfermeiras residentes em obstetrícia na assistência ao parto. Rev Bras Saúde Mater Infant. [Internet]. jan/mar 2019 [citado em 20 dez 2021]; 19(1):135-44. Disponível em:

- <https://www.scielo.br/j/rbsmi/a/btdZrZ4bX TQpcj6qnyLDxSm/?format=pdf&lang=en>
6. Minayo MCS, organizadora. Pesquisa social: teoria, método e criatividade. Petrópolis: Editora Vozes; 2016 [citado em 20 dez 2021]. 67 p. (Série Manuais Acadêmicos)
7. Nascimento LCN, Souza TV, Oliveira ICS, Moraes JRMM, Aguiar RCB, Silva LF. Saturação teórica em pesquisa qualitativa: relato de experiência na entrevista com escolares. *Rev Bras Enferm.* [Internet]. 2018 [citado em 25 jun 2019]; 71(1):228-33. Disponível em: https://www.scielo.br/pdf/reben/v71n1/pt_0034-7167-reben-71-01-0228.pdf
8. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2016.
9. Conselho Nacional de Saúde (Brasil). Resolução Nº 466, de 12 de dezembro de 2012. Trata de pesquisas em seres humanos e atualiza a Resolução 196 [Internet]. Brasília, DF: CNS; 2013 [citado em 20 dez 2021]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/cns/2013/res0466_12_12_2012.html
10. Dias PF, Miranda TPS, Santos RP, Paula EM, Bem MMS, Mendes MA. Formação do conceito ambiência para trabalho de parto e parto normal institucionalizado. *Rev Bras Enferm.* [Internet]. dez 2019 [citado em 20 dez 2021]; 72 (Supl 3):348-59. Disponível em: <https://www.scielo.br/j/reben/a/3zktZpGzn sL4zTMnsLbNbxF/?format=pdf&lang=en>
11. Alves TTM, Paixão GPN, Fraga CDS, Lírio JGS, Oliveira FA. Atuação da enfermeira obstetra no desenrolar do trabalho de parto e parto. *Rev Enferm Atenção Saúde* [Internet]. jan/jul 2018 [citado em 25 jun 2019]; 7(1):41-50. Disponível em: <http://seer.uftm.edu.br/revistaeletronica/index.php/enfer/article/view/2282/pdf>
12. Borja TJ, Freitas WMF, Santos LS, Nascimento BGS, Lima DRA, Silva JCMC. O cuidado prestado por doulas em uma maternidade pública: o olhar das puérperas. *Rev Enferm Cent.-Oeste Min.* [Internet]. 2018 [citado em 20 dez 2021]; 8:e2878. Disponível em: <http://seer.ufsj.edu.br/index.php/recom/article/view/2878/2046>
13. Ministério da Saúde (Brasil), Secretaria de Ciência, Tecnologia e Insumos Estratégicos, Departamento de Gestão e Incorporação de Tecnologias em Saúde. Diretrizes nacionais de assistência ao parto normal: versão resumida [Internet]. Brasília: Ministério da Saúde; 2017 [citado em 20 dez 2021]. 51 p. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/diretrizes_nacionais_assistencia_parto_normal.pdf
14. Souza SR, Leão IMM, Almeida LA. A gestante no pré-parto: a fisioterapia traz benefícios? *Scire Salutis* [Internet]. ago 2018 [citado em 21 dez 2021]; 8(2): 104-14. Disponível em: <https://sustenere.co/index.php/sciresalutis/article/view/CBPC2236-9600.2018.002.0011/1283>
15. Ministério da Saúde (Brasil). Resolução Nº 36, de 03 de junho de 2008. Dispõe sobre Regulamento Técnico para Funcionamento dos Serviços de Atenção Obstétrica e Neonatal [Internet]. Diário Oficial da União, Brasília, DF, 3 jun 2008 [citado em 21 dez 2021]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/anvisa/2008/res0036_03_06_2008_rep.html
16. World Health Organization. WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: WHO; 2018. 195 p. Disponível em: <http://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf;jsessionid=668165211489BAB9E7D347CB903C1885?sequence=1>
17. Wei S, Wo BL, Qi HP, Xu H, Luo ZC, Roy C, et al. Early amniotomy and early oxytocin for prevention of, or therapy for, delay in first stage spontaneous labour compared with routine care. *Cochrane Database Syst Rev.* [Internet]. 2013 Aug [citado em 03 jan 2021]; 7(8):CD006794. doi: 10.1002/14651858.CD006794.pub4
18. Aasheim V, Nilsen A, Reinar L, Lukasse M. Perineal techniques during the

second stage of labour for reducing perineal trauma. Cochrane Database Syst Rev. [Internet]. 2017 Jun [citado em 03 jan 2021]; 6(6):CD006672. doi: 10.1002/14651858.CD006672.pub3

19. Dudley LM, Kettle C, Ismail KMK. Secondary suturing compared to non-suturing for broken down perineal wounds following childbirth. Cochrane Database Syst Rev. [Internet]. 2013 Sep [citado em

03 jan 2021]; (9):CD008977. doi: 10.1002/14651858.CD008977.pub2

20. Gomes ML, Moura MAV, Souza IEO. Obstetrical practice by nurses in institutional childbirth: a possibility for emancipatory know ledge. Texto & Contexto Enferm. [Internet]. 2013 Jul/Set [citado em 21 dez 2021]; 22(3):763-71. Disponível em: <https://www.scielo.br/j/tce/a/BntrD3VQwcB6bYG5xrDJz6q/?lang=en&format=pdf>

RECEIVED: 06/07/2020
APPROVED: 03/11/2021
PUBLISHED: Dec/2021