

## PERINATAL CARE PRACTICES IN NORMAL RISK MATERNITY HOSPITALS: AN EVALUATION IN THE WOMEN'S PERSPECTIVE\*

Giseli Campos Gaioski Leal<sup>1</sup>, Lillian Daisy Gonçalves Wolff<sup>2</sup>, Luciana Schleder Gonçalves<sup>3</sup>, Aida Maris Peres<sup>4</sup>, Fábio André Miranda de Oliveira<sup>5</sup>

**ABSTRACT:** The study aimed to evaluate perinatal care practices in normal risk maternity hospitals, in the women's perspective. It is evaluative, transversal research with a quantitative approach, undertaken in three public maternity hospitals in a state capital in the South of Brazil. The probabilistic sample was made up of 95 women who experienced normal birth without complications, and who were inpatients on the Maternity Ward. Data were collected between May and July 2014, through a structured interview and were subjected to descriptive analysis and frequency analysis. Evidence was found of incorporation of practices recommended by the World Health Organization in the maternity hospitals' routines; other practices, however, need to be improved. The results provide information which is useful for managers, with a view to ensuring the women's reproductive rights.

**DESCRIPTORS:** Perinatal care; Public health policy; Reproductive rights; Health Evaluation; Patient Outcome Assessment.

### PRÁTICAS DE ATENÇÃO PERINATAL EM MATERNIDADES DE RISCO HABITUAL: AVALIAÇÃO NA PERSPECTIVA DE MULHERES

**RESUMO:** O objetivo da pesquisa foi avaliar práticas de atenção perinatal em maternidades de risco habitual, na perspectiva de mulheres. Pesquisa avaliativa, transversal, de abordagem quantitativa, realizada em três maternidades públicas de uma capital do Sul do Brasil. A amostra probabilística constituiu-se de 95 mulheres que vivenciaram o parto normal e nascimento sem intercorrências, internadas no Alojamento Conjunto. Dados coletados entre maio e julho de 2014, mediante entrevista estruturada, foram submetidos à análise descritiva e de frequência. Há evidências de incorporação de práticas recomendadas pela Organização Mundial de Saúde na rotina das maternidades, entretanto outras necessitam ser aprimoradas. Os resultados fornecem informações úteis aos gestores, visando a garantia dos direitos reprodutivos das mulheres.

**DESCRIPTORIOS:** Assistência perinatal; Políticas públicas de saúde; Direitos reprodutivos; Avaliação em saúde; Avaliação de resultados da assistência ao paciente.

### PRÁCTICAS DE ATENCIÓN PERINATAL EN MATERNIDADES DE RIESGO HABITUAL: EVALUACIÓN EN LA PERSPECTIVA DE MUJERES

**RESUMEN:** Investigación cuyo objetivo fue evaluar prácticas de atención perinatal en maternidades de riesgo habitual, en la perspectiva de mujeres. Investigación de evaluación, transversal, de abordaje cuantitativo, realizada en tres maternidades públicas de una capital del Sur de Brasil. La muestra probabilística se constituyó de 95 mujeres cuyo parto fue natural y nacimiento del hijo sin incidentes, internadas en Alojamiento Conjunto. Los datos fueron obtenidos entre mayo y julio de 2014, por entrevista estructurada, siendo sometidos a análisis descriptivo y de frecuencia. Hay evidencias de incorporación de prácticas recomendadas por la Organización Mundial de Salud en la rutina de las maternidades, sin embargo otras necesitan ser perfeccionadas. Los resultados revelan informaciones provechosas a los gestores, para la garantía de los derechos reproductivos de las mujeres.

**DESCRIPTORIOS:** Asistencia perinatal; Políticas públicas de salud; Derechos reproductivos; Evaluación en salud; Evaluación de resultados de la asistencia al paciente.

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<sup>1</sup>RN. M.A in Nursing. Lecturer in Nursing, Federal University of Paraná. Curitiba, State of Paraná (PR), Brazil.

<sup>2</sup>RN. Ph.D in Production Engineering. Lecturer on the Postgraduate Program in Nursing, Federal University of Paraná. Curitiba, PR, Brazil.

<sup>3</sup>RN. Ph.D in Nursing. Lecturer on the Postgraduate Program in Nursing, Federal University of Paraná. Curitiba, PR, Brazil.

<sup>4</sup>RN. Ph.D in Nursing. Federal University of Paraná. Curitiba, PR, Brazil.

<sup>5</sup>RN. M.A in Nursing. Lecturer at the International University Center. Curitiba, PR, Brazil.

#### Corresponding author:

Giseli Campos Gaioski Leal  
Universidade Federal do Paraná  
Av. Prefeito Lothário Meissner, 3400 - 80210-170 - Curitiba, PR, Brasil  
E-mail: gisagaioski@yahoo.com.br

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## ● INTRODUCTION

In Brazil, the Ministry of Health instituted the Stork Network (*Rede Cegonha*) (RC) in 2011. This policy relates to labor and birth and presents a new care model with a national ambit and was operationalized through the Unified Health System (SUS). It is a care network which aims to guarantee women their rights in reproductive planning and in humanized care during pregnancy, birth and the puerperium, and to assure the right to the safe birth and healthy development of the child<sup>(1)</sup>.

The Stork Network is organized in federative units and respective municipalities so as to viabilize healthcare actions focused on the maternal and child needs, through the articulation of the health services and the systems of support, logistics and governance.

This care model is based in the principles of the humanization of the care. It follows the programs of the Ministry of Health which preceded it, and shows improvements with the aim of: ensuring the rights assured to the woman, to the newborn (NB) and to the child; to broaden access, embracement and the quality of the prenatal care; to support urgent and emergency transport; to promote the undertaking of linking between the pregnant woman and a center of excellence in childbirth; to foster the undertaking of safe labor and birth, through the use of good care practices recommended by the World Health Organization (WHO)<sup>(2)</sup>; to support the presence of the companion of the woman's choice during birth; to guarantee access to family planning; and quality, resolute care for the child from 0 to 24 months old<sup>(1)</sup>.

Comprehensive and humanized prenatal and puerperal care requires organization if it is to meet the woman's individual needs during the gestational and puerperal periods, through the use of appropriate means and resources and in accordance with up-to-date scientific evidence<sup>(3)</sup>. The WHO has recommended good care practices for labor and birth for 20 years, but there are practices which have not been effectively incorporated into the Brazilian services. In this regard, it falls to the management of the health services to administrate the resources, whether these are professional or material or related to physical and financial capital, and information, so that the reproductive rights may be guaranteed through humanized and evidence-based care.

With a view to the continuous improvement of perinatal care, it is necessary to develop evaluations which may identify occasional occurrences which are not in conformity with current policy. One way to investigate whether the reproductive rights are indeed guaranteed to the female users of the SUS is to ask these directly.

The objective of this study, therefore, was to evaluate the perinatal care practices from the perspective of women in normal risk maternity hospitals. For this study, the perinatal period was understood as that between the woman's admission to the maternity hospital through to her discharge, which takes place 48 hours postpartum, and the practices had as their standard the WHO recommendations, which are ratified by the Stork Network, with a focus on guaranteeing the reproductive rights.

## ● METHOD

This is an evaluative, transversal study with a quantitative approach, undertaken in three normal risk SUS maternity hospitals in the city of Curitiba in the Brazilian State of Paraná (PR). The probabilistic sample of 95 participants corresponded to the sum of the percentage calculated relative to the mean monthly number of women who had normal births in the public maternity hospitals in 2013 (n=6011), namely: Maternity hospital "A", 30 (31.6%) participants; Maternity hospital "B", 19 (19.7%) participants; and Maternity hospital "C", 46 (48.6%) participants. A level of confidence of 95%, and an adjustment of 10% for possible losses was considered.

The inclusion criteria for the participants were: women of any age, whose normal births took place without complications and with a live birth, and who were inpatients in the Maternity Ward (MW) between the 24th and 48th hour following birth. The exclusion criteria were the women who had some complication in the birth or whose newborns did not remain on the Maternity Ward.

The recruitment of the probable participants was undertaken on each day of the data collection, based on the listing of puerperae who were inpatients on the MW. The data collection instrument was developed based on the care practices for normal labor and birth recommended by the WHO<sup>(2)</sup>, and ratified by the Stork Network<sup>(1)</sup>. A pretest was undertaken, through four interviews, whose data were not counted in the analysis. The other data collected were subjected to simple descriptive analysis and to frequency analysis.

The structured interviews with the participants took place in the period 26th May – 1st July 2014, in the wards (105 beds) of the MW, lasting approximately 30 minutes, the meeting's privacy being guaranteed through individual interview held at the bedside of each interviewee.

The study is part of the Evaluation of Perinatal Care in Normal Risk Maternity Hospitals in Curitiba Project (*Projeto Avaliação da Atenção Perinatal em Maternidades de Risco Habitual de Curitiba-PR*), approved on 16th May 2014, under Certificate of Presentation for Ethical Consideration (CAAE) 25324513.0.0000.0102. The ethical precepts currently in place were respected<sup>(4)</sup> and the Terms of Free and Informed Consent (TFIC) were signed by the participants.

## ● RESULTS

In the sample, there was a predominance of women aged between 15 and 38 years old, with a mean age of  $23.95 \pm 5.58$ ; and median age of 23 years old; 34 (35.79%) of the women stated that they had not completed senior high school; 43 (45.26%) stated that they were housewives; 79 (83.16%) cohabited or are married; and that they would have the presence of the partner during the pregnancy 87 (91.58%).

The prenatal monitoring of 76 (74.74%) women was undertaken in Basic Health Centers. The number of consultations attended varied between 2 and 18, with a mean of  $8 \pm 3.12$ . It is emphasized that 66 (69.47%) of the women attended 7 or more prenatal consultations.

Regarding obstetric antecedents, 55 (57.89%) women are multiparous; and 30 of them (30.52%) had experienced from 3 to 5 pregnancies; 41 (43.16%) women have experienced six births; and only 13 (13.16%) had had a miscarriage.

Also evaluated were the Good Care Practices in Labor and Birth which guide the handling of normal births, which were organized into categories (A, B, C and D) in accordance with the scientific evidence which these good practices refer to.

Table 1 presents the useful practices which are to be encouraged (Category A) and the practices which are clearly harmful or inefficacious which are to be eliminated (Category B) according to the WHO recommendations; as well as the results obtained in the joint evaluation of the three maternity hospitals in relation to the care for the women in the prepartum and postpartum periods (n=95).

In relation to the monitoring of physical well-being, it was observed that 23 (24.21%) participants were able to choose the position in which they wanted to have their child, and the positions chosen and adopted were lateral and dorsal, on all fours (kneeling and with the hands supported on a surface), the vertical position (standing), the gynaecological position and squatting in the shower.

In relation to the monitoring of emotional well-being, 89 (93.68%) women mentioned that the professionals call them by their first name, in all the places of attendance: Admissions Room, the Pre-delivery Room and Delivery Room and in the Maternity Ward. Besides this, 71 (74.74%) participants asserted that the professionals identified themselves when assisting them, and 74 (77.89%) of them mentioned that the professionals who attended them allowed them to express their feelings, listening to their complaints and clarifying their doubts. For 70 (94.59%) of them, the approach used most was dialogue. The receiving of information and advice regarding the procedures was mentioned by 52 (54.74%) participants.

Although the mother's skin contact with the child soon after birth was mentioned by 68 (71.58%) of the participants, the time of this contact varied from 1 minute to 1 hour, with a mean of 8 minutes and a median of 5 minutes.

Table 2 describes the practices without scientific evidence, which are to be used with caution (Category C), and the practices frequently used inappropriately (Category D) as well as the results obtained in the joint evaluation of the three maternity hospitals regarding the care for the women in the prepartum and postpartum periods (n=95).

Table 1 - Perinatal care practices referent to WHO Categories A and B and results in Normal Risk Maternity Hospitals. Curitiba, PR, Brazil, 2014

<b>Practices demonstrated to be useful and which must be encouraged (Category A)</b>	<b>Yes f (%)</b>	<b>No f (%)</b>
Respect for the mother's choice regarding place of birth; and provision of obstetric care where she is when the birth was imminent, where birth is viable and safe and where the mother feels safe and confident.	23 (24.21)	72(75.79)
Respect for the woman's right to privacy, and empathetic support by the service providers during Labor/birth.	74 (77.89)	21(22.11)
Provision to the women regarding all the information and explanations which they wish for.	52 (54.73)	43(45.26)
Offering of fluids orally during labor/birth.	37 (38.95)	58(61.05)
Fetal monitoring through intermittent auscultation.	86 (90.52)	9 (9.48)
Noninvasive and nonpharmacological methods of pain relief, such as massage and relaxation techniques, during labor.	79 (83.16)	16(16.84)
Freedom of position and movement, and encouragement for non-supine positions during labor.	69 (72.64)	26(27.36)
Prophylactic administration of oxytocin in the third stage of birth in women with risk of postpartum hemorrhage.	95 (100)	0
Early direct skin contact between mother and child	68 (71.58)	27(28.42)
Support to begin breast-feeding in the first hour after birth	18 (18.95)	77 (81.05)
<b>Practices which are clearly harmful or inefficacious, which are to be eliminated (Category B)</b>	<b>Yes f (%)</b>	<b>No f (%)</b>
Routine use of enemas.	18 (18.95)	77 (81.05)
Routine use of trichotomy.	14 (14.73)	81 (85.27)
Routine intravenous infusion during labor, and administration of oxytocin at any point prior to the birth, in such a way that does not make it possible to control its effects.	49 (51.58)	46 (48.42)
Routine use of the supine position during labor.	69 (72.63)	26 (27.37)
Routine use of the lithotomy position with or without stirrups during labor.	72 (75.79)	23 (24.21)

Table 2 - Perinatal care practices referent to WHO Categories C and D, and results in Normal Risk Maternity Hospitals. Curitiba, PR, Brazil, 2014

<b>Practices without sufficient evidence for supporting clear recommendation and which are to be used with caution (Category C)</b>	<b>Yes f (%)</b>	<b>No f (%)</b>
Fundal pressure during labor.	37 (38.95)	58 (61.05)
Routine use of oxytocin during the third stage of labor.	95 (100)	0
<b>Practices frequently used inappropriately (Category D)</b>	<b>Yes f (%)</b>	<b>No f (%)</b>
Restricted fluid intake during labor.	58 (61.05)	37(38.95)
Repeated or frequent vaginal examinations, especially by more than one service provider.	94 (98.95)	1 (1.05)
Correction of contractions through use of oxytocin.	49 (51.58)	43 (48.42)
Routine transference of the parturient woman to another room at the beginning of the second stage of labor.	50 (52.63)	45 (47.37)
Liberal and routine use of episiotomy.	34 (35.79)	61 (64.21)



## ● DISCUSSION

In Brazil, women with a higher educational level presented, between 2000 and 2009, a higher proportion of live births and seven or more prenatal consultations, while women who mentioned having “no education” represented a lower proportion of live births and undertook fewer prenatal consultations<sup>(5)</sup>.

In the study, it was observed that 69 (47%) of the participants undertook more than 7 prenatal consultations. The number of these consultations is directly related to better maternal and child health indicators. There is evidence that routine prenatal care can prevent maternal and perinatal morbidity and mortality, as it makes it possible to detect and treat health issues as they are encountered, as well as reducing risk factors which can bring complications for the health of the woman and baby<sup>(6)</sup>.

The percentage (83.16%) of the participants in the sample who cohabit or are married resembles that found in a national study which observed that 83.6% of the puerperae in a public maternity hospital were married or lived with a partner<sup>(7)</sup>. The condition of living with the partner, mentioned by the participants, is consistent with the Brazilian context, in which more than one third of unions involve cohabitation. This type of relationship increased from 28.6% in 2000 to 36.4% in 2010<sup>(8)</sup>.

Women in labor must be attended by the health service providers holistically<sup>(1-2)</sup>, throughout the perinatal period in which they receive inpatient treatment. However, it was evidenced that a minority of the participants were able to choose the position in which they wanted to have their child.

It is emphasized that the women must be encouraged to give birth in the position which is most comfortable for them, although the scientific evidence is favorable to the nonsupine positions<sup>(9)</sup>. When they remain in a horizontal position, the women may become more prone to compression of the major blood vessels by the uterus, and to present difficulty in gaseous exchange between mother and child, as well as in effective reduction of the uterine contractions<sup>(10)</sup>.

The practices recommended by the WHO correspond with the perspective of the humanization of the care. In this regard, humanizing is also to respect peoples' individuality and knowing how to see and listen to the other, as well as to provide the care with respect to the women's culture, beliefs, values and diversity of opinions<sup>(11)</sup>.

Considering the presence of the companion can be an indicator of quality, safety and of respect for the reproductive rights in birth care on the part of the institution's professionals and managers<sup>(12)</sup>. Consequently, all Brazilian women have the right to choose a partner during the periods of labor and birth and the immediate postpartum period, in both public and private services<sup>(13)</sup>.

It was also observed that the health professionals who attend the births (nurses and physicians) in the maternity hospitals are encouraging skin contact between mother and child for the majority of the women, although the time of contact was below 10 minutes. They are, however, still leaving much to desire in relation to encouraging the newborn to breast-feed in the first hour postpartum.

Brazilian health policy has instituted comprehensive and humanized care for the newborn, in relation to the appropriate care during labor and birth and, principally, in relation to good mother-and-child care practices. As a consequence, the newborn is ensured skin contact with the mother immediately and continuously<sup>(14)</sup>.

One study provided evidence that the reasons for stopping this contact may be related to the mother's request, or to requests on the part of the team with a view to beginning the first care measures following the birth. The situation may be related to the team's anxiety and to the hurry to undertake the procedures, principally when the births occur at the end of the shift or when there is an overload of work in the department<sup>(15)</sup>.

In relation to unnecessary interventions, such as the enema and trichotomy, these practices continue to be prescribed and undertaken for a minority of the women in the maternity hospitals evaluated, a fact which corroborates what is recommended by the WHO<sup>(2)</sup>. The present study corroborates this finding and evidences that, in the present context, these procedures have come to be considered to be unnecessary and/or iatrogenic in the services<sup>(16)</sup>.

Approximately half of the participants had their birth induced through the administration of oxytocins. Induction of labor is classified as an elective or therapeutic conduct. Those arranged for a particular point in time by either the physician or the mother are considered elective. However, the therapeutic indications are considered when there is risk to the fetus, through remaining in the uterus, this being able to take place due to the premature breaking of the ovular membranes or to an ovular infection; due to the fetus itself, such as macrosomia and limited intra-uterine growth; to clinical maternal complications, such as hypertension, diabetes, kidney disease and pneumopathies; and to gestational age, such as a prolonged pregnancy<sup>(17)</sup>.

More than half of the participants were taken to the delivery room during labor, where they remained in the lithotomy position, contrasting with the conditions in the pre-delivery room, in which the women have the freedom to adopt other positions.

One study on the impact of the positions on the birth and on the well-being of the woman and child revealed there to be evidence that women encouraged to use verticalized positions present the first and second stages of labor as shorter, present less pain, and, consequently, present an increase in the level of satisfaction in relation to the experience of birth, in comparison with women who experienced this in the supine or lithotomy position<sup>(18)</sup>.

The percentage of 38.95% of the participants who mentioned that they were subjected to the Kristeller Maneuver – fundal pressure - is similar to that found in another Brazilian study (37%)<sup>(19)</sup>. Professionals from various countries continue to undertake this frequently during the second stage of labor, on the premise that they can accelerate the birth. Besides the mother's discomfort, it is believed that this may be harmful to the uterus, perineum and fetus, but there is no scientific evidence regarding its real utility<sup>(20)</sup>.

The application of prophylactic uterotonics prior to the expelling of the placenta is recommended, such as oxytocin, for the prevention of postpartum hemorrhage, which can lead to a lethal outcome in 10 minutes. This is, therefore, prophylaxis of the relevant type and which must be undertaken cautiously<sup>(21)</sup>. In this case, each health service must establish its own protocol for the prevention of postpartum hemorrhage, based on scientific evidence, so as to contribute to reducing maternal mortality and serious complications for the woman<sup>(22)</sup>.

Studies reveal that the use of prophylactic oxytocin reduces postpartum hemorrhage superior to 500ml, as well as the necessity of therapeutic uterotonics, when compared to the use of placebos. If intravenous use is not possible, use via an intramuscular route presents the same effect and prophylactic benefits<sup>(23)</sup>.

In relation to the high number of vaginal examinations observed in this study, it is emphasized that these should be limited when the labor is progressing normally. Under no circumstances should the woman be forced to undergo the vaginal examination repeatedly, or at an interval of less than two hours<sup>(20)</sup>.

Episiotomy was also undertaken for more than one third of the participants. Currently, the scientific evidence recommends that it should not be undertaken routinely, as it does not protect the pelvic floor. Furthermore, it can cause pain and discomfort in the area, or cause bleeding and intra- and post-operative complications<sup>(24)</sup>.

It was observed that restriction of fluids during labor still occurs in the maternity hospitals researched, a practice which is not advisable for women with a low risk of complications<sup>(25)</sup>. In relation to the prescription of restriction on intake of food and fluids by the health professionals, the conditions of each woman must be taken into account. The benefits of nutrition based on the wishes of the parturient woman are real.

This study's results point to issues commented on by authors on Brazilian obstetric practice, in which there is a hurry to provoke the birth, without respecting the dynamic of each labor and women's autonomy in their birth process. The controlling of the time, and professionals imposing on the woman's wishes, are examples of the excessive levels of interventions which commonly result in unnecessary cesareans, causing birth care in Brazil to be focused on the decision of the professional who undertakes the birth, rather than on the natural progression of the woman's body<sup>(19)</sup>.

## ● CONCLUSION

Services which are committed to quality perinatal care need to follow the WHO recommendations relating to care practices for labor and birth, ratified by the Stork Network, with respect to the reproductive rights ensured through the Brazilian public policies.

In the normal risk maternity hospitals evaluated, some practices are being applied in accordance with that recommended by the WHO and the Brazilian Public Policies, which demonstrates an effort for the undertaking of humanized and quality care in labor and birth.

There are, however, perinatal care practices which need to be reinforced in these maternity hospitals, principally in relation to what the woman in labor and birth has a right to. Among these, emphasis is placed on: fluid intake; the choice of verticalized positions and free movement, the use of nonpharmacological methods for pain relief, and receiving information regarding the procedures.

It is recommended that, in conjunction with the multi-professional team, the following unnecessary practices should be reviewed: the routine use of fasting, trichotomy, enema and intravenous infusion in labor; and that the importance of the woman's right to continuous skin contact with the newborn and breast-feeding in the first hour postpartum must be reinforced.

The results of the perinatal evaluation undertaken in the perspective of the women attended in labor and birth in the maternity hospitals studied provide information which is useful for managers. They may contribute to planning continuous improvements in the obstetric practices, with a view to guaranteeing safe, planned and quality vaginal births.

It is recommended that as well as evaluations in the perspective of female service users, evaluations should also be undertaken in the perspective of managers, health professionals and family members. These evaluations need to be institutionalized and undertaken periodically, with a view to the monitoring and continuous improvement of the perinatal care.

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