

HUMANIZATION PRACTICES WITH PREGNANT WOMEN IN THE HOSPITAL ENVIRONMENT: INTEGRATIVE REVIEW

PRÁTICAS DE HUMANIZAÇÃO COM PARTURIENTES NO AMBIENTE HOSPITALAR: REVISÃO INTEGRATIVA

PRÁCTICAS DE HUMANIZACIÓN CON PARTURIENTAS EN EL ÁMBITO HOSPITALARIO: REVISIÓN INTEGRATIVA

Damião Silva¹
Berenice Temoteo da Silva²
Tatiana Franco Batista³
Quessia Paz Rodrigues⁴

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Objective: to analyze the scientific output of health professionals about the humanizing practices in labor and childbirth. **Method:** an integrative literature review was carried out in the SciELO and LILACS databases in May 2016 with the following descriptors: “childbirth”, “humanizing delivery”, “delivery rooms”, “hospitals”, “hospitalizations”, “maternity hospitals”, “hospital care”, “humanization of assistance” and “pregnant women”. The time frame was from 2011 to 2015. Twenty-one articles were selected. **Results:** humanizing care provided to pregnant women was related to care practices and to a relational subjective aspect. **Conclusions:** humanizing practices carried out with pregnant women in the hospital environment comply with the National Humanization Policy and with Rede Cegonha’s recommendations of good practices for childbirth care provided to women during labor and childbirth, which are relevant initiatives capable of improving quality of parturition.

Descriptors: Parturition. Humanization of assistance. Pregnant women.

Objetivo: analisar a produção científica de profissionais de saúde sobre as práticas de humanização no trabalho de parto e parto. Metodologia: revisão integrativa de literatura realizada nas bases de dados SciELO e LILACS no mês de maio de 2016 com os descritores: “parto”, “parto humanizado”, “salas de parto”, “hospitais”, “hospitalizações”, “maternidade”, “assistência hospitalar”, “humanização da assistência” e “gestantes”. O recorte temporal foi de 2011 a 2015. Foram selecionados 21 artigos. Resultados: o cuidado humanizado prestado à parturiente esteve relacionado às práticas assistenciais e à dimensão subjetiva relacional. Conclusão: as práticas de humanização realizadas com a parturiente no ambiente hospitalar coadunam-se com a Política Nacional de Humanização e com as recomendações de boas práticas de atenção ao nascimento da Rede Cegonha dispensadas às mulheres no trabalho de parto e parto, iniciativas relevantes e capazes de agregar qualidade ao processo de parturição.

Descritores: Parto. Humanização da assistência. Gestante.

¹ Nurse, Salvador, Bahia, Brazil. dmsilva2011@hotmail.com

² Doctoral student in Public Health by the Graduate Program in Public Health, Collective Health Institute, Universidade Federal da Bahia Bahia, Salvador, Bahia, Brazil.

³ Master’s degree in Nursing, Professor of the Nursing Department at Faculdade Ruy Barbosa, Salvador, Bahia, Brazil.

⁴ Doctoral student in Nursing by the Graduate Program in Nursing of the School of Nursing, Universidade Federal da Bahia, Salvador, Bahia, Brazil.

Objetivo: analizar la producción científica de profesionales de salud sobre las prácticas de humanización en el trabajo de parto y el parto. Metodología: revisión integrativa de literatura realizada en bases SciELO y LILACS, durante mayo de 2016, con los descriptores: "Parto", "Parto Humanizado", "Salas de Parto", "Hospitales", "Hospitalizaciones", "Maternidad", "Atención Hospitalaria", "Humanización de la Atención" y "Mujeres Embarazadas". El recorte temporal fue de 2011 a 2015. Fueron seleccionados 21 artículos. Resultados: la atención humanizada brindada a la parturienta estuvo relacionada a las prácticas de asistenciales y a la dimensión subjetiva relacional. Conclusión: las prácticas de humanización realizadas con la parturienta en el ámbito hospitalario condicen con la Política Nacional de Humanización y con las recomendaciones de buenas prácticas de atención al nacimiento de la Rede Cegonba realizadas con las mujeres en el trabajo de parto y parto, iniciativas relevantes que suman calidad al proceso de parición.

Descriptores: Parto; Humanización de la Atención. Mujeres Embarazadas.

Introduction

Childbirths in Brazil have taken place mainly in institutionalized environments, with health professionals as the main players. In 2011, 99% of childbirths were performed in hospitals or other health institutions. Along with the predominance of hospital childbirths, there has been an excessive medicalization of childbirth, as well as an increase of cesarean sections, with a national rate of nearly 54% in 2011. This rate is well above the recommendations of the World Health Organization (WHO), which ranges from 5% to 15% of childbirths⁽¹⁾.

According to the national monitoring report of the Millennium Development Goals (MDGs), the increase in the number of cesarean sections affects the maternal mortality ratio directly, which is a barrier to the achievement of the minimum mortality rate in developed countries. However, there was a significant decrease in maternal deaths, from 141 to 64 per 100,000 live births, between the last decade of the 20th and the first decade of the 21st century. A decrease in the rate of deaths resulting from direct obstetric causes is pointed as the main reason for this decrease, since they accounted for 126 deaths in 1990 and 43 deaths in 2011. This represents a decrease of nearly 67%⁽¹⁾. These numbers confirm the results of a study carried out in 37 municipalities in Bahia, where maternal deaths caused by direct obstetric reasons accounted for 62.8% of deaths of women in reproductive age occurred in hospitals of the surveyed region⁽²⁾.

The improvements made in the scope of women's health over the last decades are the result of different collective efforts, especially of the commitment of social movements. Maternal deaths are almost always avoidable, especially when qualified and timely care services are provided. In that sense, maternal death, whatever its percentage, is considered as a serious infringement of women's reproductive rights. This certainly resulted in the issue being considered as one of the MDGs.

The commitment undertaken by the Brazilian government and the creation of the Unified Health System (SUS, as per its acronym in Portuguese) resulted in a broader access to health services and a significant decrease in maternal deaths over the last decade of the last century. Figures of 1990 show a decrease by 75% of maternal deaths until 2015. However, the objective of 35 deaths per 100,000 live births has not been achieved, with 64 deaths in 2015, nearly twice as high as the expected rate⁽³⁾.

In addition to the positive change in the aforementioned rate, there have been significant qualitative improvements in the health care provided to pregnant women. Some aspects that can be mentioned include the 2005 regulation of the right to an accompanying person during labor, including the presence of a doula in public hospitals; the inclusion of compulsory investigation of deaths of women in reproductive age; and the creation of Maternal Death

Committees, currently implemented across the country⁽⁴⁻⁵⁾. Nevertheless, these achievements did not happen by chance. Pressure made by women's movements, who reacted firmly against the excessive medicalization and counter-hegemonic initiatives of health professionals resulted in achievements that were included in health policies.

Thus, humanization of assistance has gained space on the agenda of health policies. The Ministry of Health created the Program for Humanization of Prenatal and Childbirth and the Program for Humanization of Hospitals in 2000. In June 2011, Rede Cegonha (Stork Network) was created, which, among other objectives, ensures the right to humanized care to pregnant women.

With regard to aspects related to actions for childbirth humanization, Rede Cegonha follows, along with more systemic aspects, WHO's recommendations regarding good practices of labor and childbirth. Methods that are proven to be useful in the conduction of childbirth advocated by WHO consist of, among others: making sure mothers choose the place and type of childbirth and their accompanying person; women's privacy; freedom of position and movement during labor; ensuring the provision of information needed; availability of fluids for oral intake during labor and childbirth; encouraging the use of non-invasive and non-pharmacological methods for pain relief during labor, such as massage and relaxing techniques; monitoring the evolution of childbirth by means of a partogram and the emotional and physical well-being during labor and childbirth⁽⁶⁾.

Beyond the clinical guidelines of childbirth humanized assistance, principles and values also guide the care provided to pregnant women. With the advent of the National Humanization Policy (NHP) in 2003, embracement, bonding, prominence and autonomy went on to be encouraged in the scope of the relationship between health professionals and patients⁽⁷⁾. This subjective dimension of care was fostered with the aim to permeate all health practices, including those performed in labor.

Different elements justify the development of this study on humanizing practices in labor, such as the continuity of childbirth medicalization, the maintenance of unacceptable maternal death rates, and the proposal of humanization of assistance as a change of perspective regarding childbirth. Hence, the research question that motivated the development of this study was: What humanizing practices are actually being performed with pregnant women in hospital environments? Therefore, the objective of this study was to analyze the scientific output of health professionals about humanizing practices in labor and childbirth.

Method

This study is an integrative literature review, which allowed systematically gathering scientific evidence around a research problem and thus progressing in the construction of scientific knowledge⁽⁸⁻⁹⁾.

The literature search was performed in the following databases: SciELO (Scientific Electronic Library Online) and LILACS (Latin American and Caribbean Center on Health Sciences Information). Words used to gather articles found in the literature were terms recorded on the DeCS website (Health Science Descriptors) of the Virtual Health Library (VHL), namely: "childbirth", "humanizing delivery", "delivery rooms", "hospitals", "hospitalizations", "maternity hospitals", "hospital care", "humanization of assistance" and "pregnant women". Each descriptor was cross-checked with the others by means of Boolean operator "AND".

The research time frame was from 2011 to 2015. The choice for this time frame was due to the launch of Rede Cegonha by the Federal Government in June 2011, which among other objectives, advocates guarantee of the right to humanizing care of women in labor and childbirth.

In order to obtain study samples, the following inclusion criteria were defined: articles available in Portuguese in which participants were

pregnant women or health professionals and in which the results showed humanizing practices carried out with women. The selection of articles was also conditioned to the performance of humanizing practices in a hospital environment and provided by health professionals.

Search in databases took place in May 2016. After the application of search filters to the aforementioned databases and the performance of descriptors cross-checks, 398 articles were obtained. Reading of titles and/or abstracts, the application of inclusion criteria and also the exclusion of duplicated studies allowed for the selection of 43 articles. After full reading of the texts, 21 studies were selected for further analysis. The reasons for the exclusion of articles after full reading were: articles that studied humanizing practices carried out with pregnant women during prenatal care or humanizing practices aimed at the newborn, even though they surveyed pregnant women in a hospital environment; studies that obtained results related to humanizing care provided to pregnant women by the accompanying person/doula; studies carried out in maternity hospitals but which dealt with pregnant women and health professionals' expectations about humanized care; and studies which addressed the perception of health professionals/pregnant women about principles of care humanization but without referring to the humanizing practices performed.

For the analysis of the selected articles, both WHO's recommendations about good practices of childbirth care and the subjective dimension of humanized care promoted by the NHP were considered. It is worthy of note that humanized care in childbirth was understood as the respect of personal, cultural, sexual and family experiences of pregnant women, as well as the incentive by health professionals to women's prominence and autonomy and their active participation in decisions related to childbirth, made along with the health staff⁽¹⁰⁾.

Results and Discussion

The profile of scientific output presented in Chart 1 about humanizing practices carried out with pregnant women in hospital environments show that most articles were published in 2011, and they account for 38%⁽⁸⁾. The main authors are female nurses, except for one, who is a physician. Publications were made in 12 journals, 10 of which (83%) are nursing journals. The journal with the highest number of publications was *Texto e Contexto*, of the Federal University of Santa Catarina, with 4 articles (33%), followed by *Revista Brasileira de Saúde Materno Infantil* of Instituto de Medicina Integral Prof. Fernando Figueira (IMIP) and *Cuidado é Fundamental*, of the Federal University of Rio de Janeiro, both with 3 studies (25%).

Chart 1 – Profiles of articles published between 2011 and 2015 on LILACS and SciELO about humanizing practices with pregnant women in a hospital environment, by author, year, profession, journal and type of study. Salvador, Bahia, Brazil – 2016 (N = 21) (continued)

Authors/Year	Main author's occupation	Journal	Type of study
Vogt SE, Diniz SG, Tavares CM, Santos NCP, Schneck CA, Zorzam B, et al., 2011 ⁽¹¹⁾	Nurse	<i>Cadernos de Saúde Pública</i>	Quantitative
Nagahama EEI, Santiago SM, 2011 ⁽¹²⁾	Nurse	<i>Revista Brasileira de Saúde Materno Infantil</i>	Quantitative

Chart 1 – Profiles of articles published between 2011 and 2015 on LILACS and SciELO about humanizing practices with pregnant women in a hospital environment, by author, year, profession, journal and type of study. Salvador, Bahia, Brazil – 2016 (N = 21)

(continued)

Authors/Year	Main author's occupation	Journal	Type of study
Oliveira ASS, Rodrigues DP, Guedes MCV, 2011 ⁽¹³⁾	Nurse	<i>Revista de enfermagem da UERJ</i>	Qualitative
Stancato K, Vergílio MSTG, Bosco CS, 2011 ⁽¹⁴⁾	Nurse	<i>Ciência Cuidado e Saúde</i>	Quantitative
Silva LM, Barbieri M, Fustinoni SM, 2011 ⁽¹⁵⁾	Nurse	<i>Revista Brasileira de Enfermagem</i>	Qualitative
Dornfeld D, Pedro ENR, 2011 ⁽¹⁶⁾	Nurse	<i>Revista Eletrônica de Enfermagem</i>	Qualitative
Busanello J, Kerber NPC, Mendoza-Sassi RA, Mano PS, Susin LRO, Gonçalves BG, 2011 ⁽¹⁷⁾	Nurse	<i>Revista Brasileira de Enfermagem</i>	Quantitative
Wei CY, Gualda DMR), Santos-Junior HPO, 2011 ⁽¹⁸⁾	Nurse	<i>Texto Contexto Enfermagem</i>	Qualitative
Enderle CF, Kerber NPC, Susin LRO, Mendoza-Sassi RA, et al., 2012 ⁽¹⁹⁾	Nurse	<i>Revista Brasileira de Saúde Materno Infantil</i>	Quantitative
Pereira ALF, Nagipe SFSA, Lima GPV, Gouveia MSF, 2012 ⁽²⁰⁾	Nurse	<i>Texto Contexto Enfermagem</i>	Quantitative
Reis TR, Zamberlan C, Quadros JS, Grasel JT, Moro ASS, 2015 ⁽²¹⁾	Nurse	<i>Revista Gaúcha de Enfermagem</i>	Quantitative
Caus ECM, Santos EKA, Nassif AA, Monticelli M, 2012 ⁽²²⁾	Nurse	<i>Escola Anna Nery Revista de Enfermagem</i>	Qualitative
Malheiros PA, Alves VH, Ragel TSA, Vargens OMC, 2012 ⁽²³⁾	Nurse	<i>Texto Contexto Enfermagem</i>	Qualitative
Guida NFB, Lima GPV, Pereira ALF, 2013 ⁽²⁴⁾	Nurse	<i>REME Revista Mineira de Enfermagem</i>	Qualitative
Silva RC, Soares MC, Jardim VMR, Kerber NPC, Meincke SMK, 2013 ⁽²⁵⁾	Nurse	<i>Texto Contexto Enfermagem</i>	Qualitative

Chart 1 – Profiles of articles published between 2011 and 2015 on LILACS and SciELO about humanizing practices with pregnant women in a hospital environment, by author, year, profession, journal and type of study. Salvador, Bahia, Brazil – 2016 (N = 21) (conclusion)

Authors/Year	Main author's occupation	Journal	Type of study
Vargas PB, Vieira BDG, Alves VH, Rodrigues DP, Leão DCMR, Silva LA, 2013 ⁽²⁶⁾	Nurse	<i>Revista de Pesquisa Cuidado é Fundamental</i>	Qualitative
Pieszak GM, Terra MG, Neves ET, Pimenta LF, Padoin SMM, Ressel LB, 2013 ⁽²⁷⁾	Nurse	<i>Rev RENE - Revista da Rede de Enfermagem do Nordeste</i>	Qualitative
Souza CM, Ferreira CB, Barbosa NR, Marques JF, 2013 ⁽²⁸⁾	Nurse	<i>Revista de Pesquisa Cuidado é Fundamental</i>	Qualitative
Silva FFA, Silva RAR, Santos FAPS, Rego AP, 2014 ⁽²⁹⁾	Nurse	<i>Revista de Pesquisa Cuidado é Fundamental</i>	Qualitative
Silva ALS, Nascimento ER, Coelho EAC, 2015 ⁽³⁰⁾	Nurse	<i>Escola Anna Nery Revista de Enfermagem</i>	Qualitative
Leal MC, Theme-Filha MM, Moura EC, Cecatti JG, Santos LMP, 2015 ⁽³¹⁾	Physician	<i>Revista Brasileira de Saúde Materno Infantil</i>	Quantitative

Source: created by the authors.

The fact that the main authors are women and nearly all of them are nurses corresponds with women's historical role in care. A recent study⁽³²⁾ about the genesis of nursing care in Brazil in 1920 found that the typically female nature of this profession shows a secular tendency of care provided by female nurses.

Another aspect to be highlighted in the scientific output about practices of humanization of assistance is that, despite no descriptor related to nursing was used, nearly all articles were published in nursing journals. On one hand, this suggests that nursing has been committed to the humanization of childbirth assistance, and on the other hand, it may suggest that female researchers have mostly limited their output to nursing, which differs from the required transdisciplinary approach to delivery and birth.

A critical reading of texts allowed us to identify elements that answer the research question of this work. For organization purposes, information was divided into three aspects, namely: Humanizing practices in care provided to pregnant women based on proven useful methods in the conduction of childbirth; Humanizing practices in care provided to pregnant women based on subjective aspects fostered by the National Humanization Policy; and Perception of pregnant women and health professionals about humanized care.

As for the aspects of humanizing practices provided to pregnant women based on proven useful methods in the conduction of childbirth, the literature mentions the presence of an accompanying person during the process of parturition. The right to an accompanying person chosen by the pregnant women at the

time of labor, childbirth and immediate postpartum was mentioned as a beneficial measure with a humanizing nature in the care of women in labor and childbirth^(11-12,14,19-21,25,29,31). However, this right was not ensured to all parturients. The respect of pregnant women's right to have someone they trust by their side was related to the existence of clear institutional rules in the studied hospitals^(26,31). The right to an accompanying person was also denied to teenage parturients who are ensured by law the right to an accompanying person as provided for in the Statute of the Child and the Adolescent (ECA, as per its acronym in Portuguese)⁽¹⁹⁾.

The law that provides for the presence of an accompanying person in the childbirth process has been in force since 2005⁽⁵⁾, although some studies^(19,26,31) indicate that the exercise of this right has been hampered by hospitals. Childbirth is a natural and social phenomenon, in which women are the major players and family appears as a nurturing environment for the new social being. It is important to note that childbirth went on to be assisted in an institutionalized environment⁽¹⁾ and often away from the family only in the 20th century. In that sense, the distance of pregnant women from their families at the time of childbirth has become a common practice quite recently and it started to be questioned in the early 20th century, when social movements managed to have the right to an accompanying person secured by law.

Another important aspect mentioned by the literature and which is in the essence of childbirth humanization is the respect for privacy of pregnant women during labor and childbirth^(17,25).

Women's choice of the place of childbirth is also part of good practices recommended by the WHO. This practice was found in the literature, in statements in which pregnant women had their autonomy when they chose a special service in a hospital where they had not had previous negative experiences⁽¹⁵⁾.

Women's participation in the choice of position and movement during labor was also reported in the literature. Women made decisions about the most comfortable position

to give birth, and they chose to walk about or to lie down during labor^(15,18,20-21). The possibility to choose the childbirth position breaks with a secular tradition of clinical assistance, in which the concept of pregnancy as a pathological event determined the horizontal position as the most comfortable for interventions during labor, to the detriment of women's well-being⁽³³⁾.

A relevant practice in care of pregnant women consists of providing pregnant women with relevant information. Clearing doubts can ease feelings of fear, longing, and uncertainty in women, and more particularly, it helps them make conscious choices regarding their childbirth. These studies indicated that women reported that they were provided with required information about labor^(12,17,19,28,30). This is an essential aspect for the encouragement of empowerment of women as players of their own childbirth. However, information provided must be discussed so a dialog about women's previous experiences can be held and, above all, communication between health professionals and pregnant women must take place in early prenatal appointments.

Another element consistent with humanization of assistance showed by the literature is the use of non-invasive and non-pharmacological methods to relieve pain and to help dilate the uterine cervix and to strengthen the pelvic muscle^(12-18,20-22,24-25,30). These studies pointed out several relaxing techniques used to promote comfort and well-being of pregnant women, such as massage, bath, music therapy, breathing exercises, use of an obstetric ball, preambulation, rocking chair and birth chair. However, it is considered that parturients' commitment to some of these methods will only be based on principles and guidelines of humanization of assistance when their preferences are taken into account regarding these practices.

The provision of food and drinks administered orally to pregnant women is also in line with humanized care. The possibility of being on a light diet throughout hospital stay is perceived by women as a positive conduct. However, even this being a humanizing practice of care of

pregnant women, it has not been consolidated as a routine in all hospitals yet^(12,18).

The presence of an accompanying person, the use of non-invasive and non-pharmacological methods for pain relief, the provision of food and drinks administered orally, the provision of relevant information to pregnant women and their participation in the choice of childbirth position, as well as the possibility to move about during labor, were conducts that were hardly ever recorded in the medical record of pregnant women⁽²¹⁾. It is important to note that it is only possible to find out whether care provided to pregnant women is in accordance with the recommendations of the NHP and Rede Cegonha if their medical records are available. This record is also important to strengthen humanizing practices so they become a routine task in maternity hospitals.

With regard to the first aspect analyzed in this study, the literature shows creative methods for the promotion of physical and emotional well-being of women in the parturition process. Nevertheless, it is important to note that the implementation of humanized practices based on proven effective methods in the conduction of childbirth is not enough to cope with the complexity of the event. Therefore, subjective aspects must be considered in the humanization of assistance.

The second aspect of humanized care given to pregnant women – Humanizing practices in care provided to pregnant women based on subjective aspects fostered by the NHP - as found in the literature, consists of subjective relational aspects encouraged by the NHP. The simple fact of not leaving them on their own, of establishing a dialog with words of incentive and praise, as well as calling them by their names, were pointed out as possibilities to create bonds and to promote a more humanized care^(16,23,30).

An empathic relationship established between professionals, pregnant women, and relatives, and an individualized care free of any coercion were found in the literature⁽²²⁾. Subjectivity of the eyes, of silence, of small gestures perceived by

health professionals regarding pregnant women's needs was reported as a possibility to carry out their comprehensive care⁽²⁸⁾. These subjective elements of humanized care are in line with the principles of the NHP.

Despite humanization of assistance being based on different interventions, such as the choice of non-pharmacological methods for pain relief, incentives to women's autonomy during labor, the provision of food and drinks administered orally, among other practices mentioned in this paper, what women perceive as humanized care is essentially related to the way they are subjectively treated by health professionals⁽³⁰⁾. Given the relevance of relational aspects in care practices, the way women perceive humanization practices stood out in the third aspect of this study: Perception of pregnant women and health professionals about humanized care.

In this aspect, the meaning of childbirth for pregnant women was highlighted. Thus, for parturients, care provided must include respect of their femininity, of a focused assistance that provides comfort to relieve pain, and above all the possibility of empowerment^(22,27). Ensuring privacy and intimacy was also mentioned⁽¹⁹⁾ as factors that favored their positive evaluation about humanized care.

With regard to health professionals, an appreciation of humanizing practices was observed, since they met subjective and objective needs of women. Professionals reported that humanized care was expressed in their interpersonal relationships, in emotions and also in adequate guidance, in the acknowledgment of parturients' needs and in the provision of care based on scientific evidence⁽²⁷⁾.

By pointing out parturients and health professionals' perception of humanized care practices, these studies showed that the performance of these care services was positively perceived by both parties of the process. In that sense, there seems to be a gap between theory and practice, although it is perceived as being positive, humanization of childbirth is still not a

reality in all maternity hospitals in the country. This finding brings about the need for further studies capable of demonstrating different determining factors around the difficulties of achieving humanized care in childbirth.

Conclusions

The three aspects that came about in the analyses of articles suggested care practices based on scientific evidence and more subjective and relational aspects inherent to humanized assistance. The latter was more widely perceived by pregnant women. The literature also showed that the authors involved in care humanization, whether they were health professionals, parturients or their relatives, valued humanized care for its ability to promote comprehensiveness of care in childbirth.

A critical review of the articles allowed us to consider that progress has been made in care of humanized childbirth in maternity hospitals, which are: legal guarantee of the presence of an accompanying person during the parturition process; acknowledgment of non-pharmacological conducts of pain relief; incentives to women's prominence; welcoming; empathic relationship between professionals, pregnant women, and relatives. Therefore, humanizing practices carried out in hospital environments comply with the principles and guidelines launched in the National Humanization Policy in 2003 in Brazil and with recommendations of Rede Cegonha, which refer to good practices to guide childbirth assistance published by the WHO in 1996.

However, it is important to note that these humanizing practices still coexist with others that are dehumanizing. The analyses of articles allowed us to understand that implementing humanization of childbirth assistance means most importantly changing the obstetrics care model, and this is a great challenge for health professionals, institutions, managers, and women who support this new way of assistance.

In agreement with the perspective of changing the care model, the Ministry of Health has encouraged the work of obstetric nurses in the monitoring of low-risk pregnancies and childbirths. These nurses, who should have a holistic training and be committed to childbirth humanization, play a key role in humanized care since they perform welcoming practices based on respect, ethics, and dignity, and they should also encourage women's prominence and autonomy in childbirth.

Humanizing practices provided to women during labor and childbirth are relevant initiatives that are able to improve the childbirth process. The participation of nurses in the care process is important, and this profession appears to be strategic for childbirth humanization, with a potential to contribute to decreasing maternal death rates.

Collaboration:

1. conception, design, analysis and interpretation of data: Damião Silva, Berenice Temoteo da Silva, Tatiana Franco Batista and Quessia Paz Rodrigues;
2. writing of the article and relevant critical review of the intellectual content: Damião Silva, Berenice Temoteo da Silva, Tatiana Franco Batista and Quessia Paz Rodrigues;
3. final approval of the version to be published: Damião Silva, Berenice Temoteo da Silva, Tatiana Franco Batista and Quessia Paz Rodrigues.

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