DOI: 10.1590/1413-81232021263.13662020

Social practices of labor and birth in Brazil: the speech of puerperal women

Neide Pires Leal (https://orcid.org/0000-0001-8793-1112) [1]
Maria Helena Versiani (https://orcid.org/0000-0002-7135-5242) [2]
Maria do Carmo Leal (https://orcid.org/0000-0002-3047-515X) [1]
Yammê Ramos Portella Santos (https://orcid.org/0000-0002-1955-7779) [1]

Abstract *The article analyzes the opinions of a group of women regarding the standard of care at maternity facilities attached to the Ministry of Health's Programa Rede Cegonha or Stork Network Program. The women's views were obtained from a questionnaire administered to 10,665 puerperal women between 2016 and 2017 as part of the survey Evaluation of good labor and childbirth care practices in maternity facilities covered by the Rede Cegonha, conducted by the Oswaldo Cruz Foundation and Maranhão Federal University. Consisting mainly of closed-ended questions, the questionnaire contained an optional open-ended question at the end that allowed women to talk freely about the standard of care received in the maternity facility. Of the 10,665 puerperal women interviewed, 2,069 gave their opinions. We undertook a critical reading of the opinions identifying four core themes, which were discussed in the light of the relevant literature: puerperal woman/health team relationship; puerperal women's right to information; presence of a companion; and quality of hospital services and facilities. Giving both praise and criticism, all the women reiterated the importance of improving the quality of public health services to ensure the humanization of childbirth in Brazil.*

Key words *Health services evaluation, Childbirth, Rede Cegonha*

[1] Escola Nacional de Saúde Pública, Fiocruz. R. Leopoldo Bulhões 1480, Manguinhos. 21041-210 Rio de Janeiro RJ Brasil. neidepiresleal@gmail.com
[2] Museu da República. Rio de Janeiro RJ Brasil.

Social practices of childbirth in Brazil

Up to the beginning of the nineteenth century, childbirth in Brazil was considered to be a "women's issue", a home practice in which only women accompanied the event, which was often performed under the care of a midwife. In general, the midwife enjoyed the full confidence of women and were consulted regarding pregnancy and newborn care. Other social practices in this field only developed after the creation of the Faculty of Medicine of Bahia (1808) and the Faculty of Medicine of Rio de Janeiro (1809). The presence of men in this hitherto strictly female environment would meet resistance from women and their families[1,2].

In the nineteenth century, efforts to convey status to scientific knowledge gained force in Brazil, directly influenced by the positivist philosophy of Auguste Comte (1798-1857). The development of scientific method would come to express the progress of the human spirit, enlightened in its upward march towards true knowledge[3]. In line with this thinking, medical training gained visibility and credibility in society, questioning the empirical knowledge of midwives and developing it under different a different guise. In the first half of the twentieth century, the well-off used doctors to perform home births. At the same time, arguments showing the advantages and safety of hospital birth over home birth gained force and the transformation of the structure of hospital care services in the 1950s proved a decisive milestone in the hospitalization process[4].

The construction of the confidence-inspiring public image of doctors articulated the understanding that childbirth cannot be performed by lay people[2]. In addition, medical advances such as forceps and the cesarean section, formerly used only in exceptional cases to save the mother's or baby's life, reinforced the idea that doctors were best equipped to perform childbirth. Pregnant women and pregnancy became people and processes that demanded medical care and childbirth ceased to be treated as a natural physiological event. Thereafter, the birth process began to be conducted by the health team, with women taking on an increasingly passive role. Placing the pregnant woman in the supine position, prohibiting fluid and food intake during labor, and recommending that the mother should stay in bed awaiting contractions are some examples of this conduct still practiced in many hospitals today.

While in the first half of the twentieth century cesarean delivery was cause for concern among doctors and the public in general, due to the high maternal mortality rate, in the 1970s people began to believe that there was a direct relationship between the drop in maternal and infant mortality and growth in the number of cesareans. This hypothesis was rejected and now we know that a combination of factors led to this outcome. The advent of blood banks, use of antibiotics, improvements in aseptic conditions in hospitals and aseptic techniques such as hand washing and glove use have all contributed to a reduction in maternal and perinatal mortality[5].

Currently, more than 90% of deliveries in Brazil take place in hospitals[6]. Within this context, we have witnessed a radical change in the approach to giving birth, centered on hospitals, doctors, technology and surgical intervention. A complete change in the physical environment, protagonists, instruments, rituals, and the dynamics of the entire process has been observed. This new approach permits excessive use of cesarean sections, with even normal-risk births being scheduled for surgery[7]. In addition, factors such as hospital routines that favor scheduled delivery, improvements in cesarean section techniques, and doctors' mastery of and confidence in the surgery have helped lead to the increased use and promotion of this practice. The cesarean section, which in the first half of the twentieth century was used in cases of extreme necessity – when the mother's or baby's life was at risk – has become a "normal" way of giving birth, being preferred by many doctors. As a result, the cesarean birth rate in Brasil is currently much higher than the rate recommended by the World Health Organization (WHO) and Pan American Health Organization (PAHO): "There is no justification for any region to have a rate higher than 10-15%"[8]. In Brazil, this rate is almost 90% in private hospitals and around 45% in the public health system[7], three times greater than that recommended by the WHO and PAHO.

The *Rede Cegonha*

The awareness of the need for a shift in the logic and social practices of childbirth care brought together public health professionals and advocates of humanized childbirth in a movement that gained force during the process that lead to the creation of Brazil's constitution and the country's public health care system, the *Siste-*

ma Único de Saúde (SUS), or Unified Health System, in 1988.

The 1990s saw the implementation of programs designed to improve labor and childbirth care[9]. Drawing on the experiences of doctors, nurses, midwives, doulas, activists, health policymakers, managers, and women, the Health Ministry created the *Program Rede Cegonha*, or Stork Network Program, in June 2011. The program consists of a network of care services provided by the SUS that seek to guarantee women the right to family planning and humanized antenatal, labor and childbirth, postpartum, and abortion care. It also aims to ensure newborns the right to a safe birth and healthy development[10]. The program provides services ranging from family planning to the first two years of life, comprising a new model of maternal and infant health care focused on humanized labor and childbirth care.

Although a detailed description of the characteristics of the Rede Cegonha is beyond the scope of this article, it is worth noting that, initially, the program focused on regions with high rates of maternal and infant mortality, subsequently embracing the principle of universality that underpins the SUS[11]. In December 2013, the *Rede Cegonha* was operating across all of Brazil's states[12]. Data from 2017 show that the program covered 5,488 municipalities[13]. The Ministry of Health's website states that the program is being gradually expanded to the whole of Brazil[14].

An evaluation of the *Rede Cegonha*

As with all public policies, the *Rede Cegonha* requires periodic monitoring and evaluation in order to confirm whether SUS resources are generating the desired health actions. As part of the planned evaluation cycles, the Ministry of Health commissioned the Oswaldo Cruz Foundation (Fiocruz) and Maranhão Federal University (UFMA) to undertake a survey of practices in the maternity facilities covered by the program between 2016 and 2017.

The survey was entitled "Evaluation of good labor and childbirth care practices in maternity facilities covered by the Rede Cegonha". The data were collected in 606 public and mixed (private facilities under contract with the SUS) facilities located in 408 municipalities covering all the country's states and the Federal District[15].

Evaluation instruments included questionnaires administered to health managers, care workers and puerperal women. The questionnaire applied to the latter consisted of 95 largely close-ended questions devised to collect general information, such as age group, level of education and number of deliveries, and information related to access to maternity services, patient welcoming practices, risk classification, right to a companion, physical conditions of the maternity facility, and ensuring skin-to-skin contact between the mother and newborn. At the end of the questionnaire, there was an open-ended question where mothers were invited to talk freely about any aspects of their experience during their hospital stay. Out of a total of 10,665 puerperal women, 2,069 answered this question.

The interviews were administered between December 2016 and October 2017 by a team of 126 interviewers. The data were recorded on an electronic form in the REDCap (Research Electronic Data Capture) web platform, creating a database.

This article focuses on the women's opinions recorded by the interviewers. In this regard, it is important to note that the transcriptions of the material recorded in the database do not necessarily represent the exact words of the women, but are rather a record of these words produced by the interviewers.

The speech of the puerperal women

Our interest in analyzing the puerperal women's freely expressed views is based on the assumption that the experiences of health service users help understand the logic and conditioning factors that influence the standard of care. A series of studies have reinforced the importance of public participation in SUS planning and evaluation processes[16]. Gabi et al.[17] confirm that level of user satisfaction is an important indicator in the evaluation of health service quality. Along the same lines, Esperidião and Vieira-da-Silva[18] highlight that satisfaction surveys are strategies that can help defend the rights of service users, recognized as key actors in the control of SUS actions in keeping with one of the system's underlying principles: public participation[19].

From this perspective, the opinions of the puerperal women in this analysis are viewed as forms of public participation, constituting a unique source of knowledge for understanding the challenges related to the quality and management of obstetric and neonatal care in Brazil. It is assumed that these women's experiences can make an active contribution to the construction

of scientific knowledge. Listening to them makes a decisive contribution to the identification of problems and development of solutions for obstetric care.

For the purposes of this study, we used the content analysis method proposed by Bardin[20] and revisited by, among others, Silva and Fossá[21], recognizing women's opinions as passive forms of inferable and interpretable communication. To this end, we read the account without losing sight of the relationships between them, seeking to identify recurring themes in the dataset. In this way, we performed the analysis within a pendular movement, moving between each opinion and the dataset as a whole, observing identifying elements that point to unifying tendencies. Each opinion was viewed not just as an element of the identity of the person who expressed it, but also as an expression of shared values.

All 2,069 records were analyzed. First, we sought to understand the meanings contained in the women's speech. We then situated the identified themes within the context of the current state of knowledge in this area, establishing links between the themes and the issues addressed by the literature, utilizing the women's opinions to reflect upon labor and childbirth care in Brazil.

The predominant perceptions in the dataset were organized into a thematic framework with four core themes: puerperal woman/health team relationship; puerperal women's right to information; presence of a companion; and quality of hospital services and facilities.

*To aid analysis, s*elected excerpts of the women's opinions are presented below exemplifying each of the four core themes.

Puerperal woman/health team relationship

The blunt observations in the dataset confirm that the opinions and feelings of parturient women in relation to the birth process matter. Going against the supposition that the health team is the sole holder of knowledge and competence in this field, some of the women complained about being seen as a patient who should simply follow instructions, participating little in decision making. Others complained that health professionals took decisions without their consent, as the following excerpts illustrate:

- During my delivery, it seemed like I was at a party I hadn't been invited to.

- There are professionals who give you more attention and there are those who don't see you.

Oliveira and Penna[22] point out that doctors often define the conduct of childbirth without talking to the pregnant women or paturient, establishing a relationship of power.

However, despite the criticism, other accounts show that the interviewees were satisfied with the attention given to their feelings and desires:

- I did the birth plan and all my preferences were met. I was able to give birth in the labor room, as I wanted. They allowed me to give birth in the position that I felt best. Oxytocin was administered for only 10 minutes, as agreed. My husband cut the umbilical cord. It was perfect! I had prepared myself for the moment, and all my requirements were met.

- I was well treated and everything that needed to be done was done. I feel complete and satisfied with the professionalism of the people here.

In other words, some of the accounts suggest that the image of capable health professionals and incapable pregnant/puerperal women is no longer a concrete reality. This means that it is plausible to say that the actions developed by the *Rede Cegonha* to promote the recognition of pregnant/puerperal women as an aware and participative social subject with rights have contributed to calling into question the supposed monopoly on knowledge of health professionals, as they reassess pregnant women and childbirth processes. These women are no longer seen as subordinate with preset roles, but rather people who should be heard and participate in decision making about childbirth, guided by their experience and feelings.

Puerperal women's right to information

Some of the interviewees were direct in saying that the lack of dialogue with the health team left room for doubt and misinterpretations in relation to the situations they experienced in the maternity facilities. Examples include the following:

- I don't know why I was left alone. I felt bad being alone.

- They didn't inform me about the dilation when I had the baby, and I think that influenced them to do an episiotomy. I'm very upset...

- I think professionals should keep women better informed about what's happening.

Pimentel and Oliveira-Filho[23] agree that women are not always kept well informed during childbirth. They highlight that in public health services it is common for women to be un-

aware of the existence of analgesic agents and non-pharmacological pain relief methods. The fact that SUS hospitals do not have physiotherapy props to help the progress of labor and birth, such birthing balls, birthing stools, birthing tubs, and a warm shower, does not justify the lack of open dialogue between the health team and pregnant woman regarding procedures aimed at building confidence. In this regard, Baldisseroto[24] maintains that healthy dialogue with the team of carers during labor and birth is a key factor influencing the satisfaction of pregnant women, advocating that the Ministry of Health should invest in staff training to this end.

However, in relation to the lack of healthy dialogue between health professionals and pregnant women in public maternity facilities, it is important to highlight that one of the strategies of the *Rede Cegonha* is staff training, providing specialist training courses and residency programs focused on maternal and infant health, including obstetric nursing[25]. In this regard, some of the interviewees acknowledged the advances made in service quality in the SUS, as the following examples show:

- I really liked the service, there's no difference between the SUS and private services.

- If I were to say anything, I would say thank you for the service; they see a human being, they help us.

- I loved the maternity facility, I liked the professionals. They respected my privacy and taught me some important things for the baby and for us.

- I thought the service was good, explaining everything right.

In contrast, when there is lack of dialogue, dissatisfaction and frustration find fertile ground, as the account below shows:

- I didn't receive adequate care, I wasn't given medication to help the contractions, despite asking. If I'd known I was going to have my child alone, I would have stayed at home.

These extreme situations show a combination of lack of dialogue and disrespect. Among other examples, women who complained about pain became the target of teasing and innuendos:

- They told me to stop screaming when I was in labor, saying that even animals give birth alone and that I should stop screaming because I wasn't mad.

- I didn't like the doctor's attitude during labor. They told me to shut up.

Socorro et al.[26] report that obstetric violence – including negligence, rudeness and painful procedures preformed without the woman's knowledge or permission – is a reality that demands not only public policies to help identify and punish acts of violence, but also training and the strengthening of health facilities to guarantee the full rights of parturient women and their babies, including the right to information. In other words, efforts are needed to promote specific obstetric care policies and invest in the training of SUS staff to ensure that cases of obstetric violence become increasingly rare and the investigation and punishment of violations are incorporated into the day-to-day functioning of the public health system.

Some authors point out that misinformation is a problem for women when choosing the type of delivery. Kottwitz et al.[27] highlight that the health team should offer advice to the pregnant woman, providing information tailored to the specific needs of each delivery, including socioeconomic and cultural factors.

Some of the interviewees signalled that the type of care they received either helped or hindered decision making about type of childbirth:

- I wanted to have a natural birth, but they didn't give me this option. The nurse said that it would take too long and that I would suffer a lot and would have to wait alone in the waiting room.

- My companion became very uncomfortable with the doctors' insistence on a natural birth, since I wanted to have a cesarean.

Arik et al.[28] underscore the importance of informing women of the risks and disadvantages of cesarean section without any clinical indication. The rate of surgical interventions in childbirth without prior diagnosis is excessively high in Brazil[29]. In many cases, the cesarean section is viewed as a way of making childbirth easier, supported by the belief that it is cleaner, more hygienic, painless, without surprises, totally safe, scheduled, and controlled. Nakano[7] remarks that a new system of labor and childbirth norms is under construction. This movement is contrary to common sense, with evidence showing that the indiscriminate use of this technique has led to an increase in maternal and infant morbidity and mortality, not to mention the unnecessarily high cost of cesarean sections for the health system. Studies show that having a cesarean section increases the risk of hemorrhage and infection in women, and can lead to death[30]. Moreover, it increases the chances of fetal death without apparent cause and having an abnormally shaped placenta in future pregnancies[31]. Cesarean delivery

of premature babies is associated with a higher chance of neonatal death and low Apgar scores at five minutes after birth[32]. However, despite the evidence indicating the adverse effects of this surgical procedure, Brazil has failed to see any significant reduction in cesarean section rates[7].

Undoubtedly, medically indicated cesarean sections should be available on the health system, constituting an important factor in the reduction of maternal and infant mortality in specific cases.

Misinformation regarding nursing competency for childbirth and postpartum care was also a factor that generated insecurity among some of the interviewees. This problem can be summed up by the following comment:

- "Women should be informed that nurses are trained in childbirth care, because they may feel insecure without the doctor present".

This comment alludes to the difficulty in breaking the medical dominance of health care, internalized as a superior and unique condition under which nurses have a purely auxiliary function.This lack of information conceals the expertise that is unique to obstetric nurses/midwives, who skillfully and knowledgeably control prenatal, labor and childbirth, and postpartum care. In reality, doctors only need to be actioned for risk pregnancies or cesareans.

Based on this understanding, the *Rede Cegonha* promotes of the delivery of vaginal birth care by obstetric nurses/midwives, with excellent results. In a study of this initiative, Gama et al.[33] showed that the inclusion of obstetric nurses/midwives in childbirth care results in less interventions such as the lithotomy position, episiotomy and the use of oxytocin to speed up labor. Moreover, it leads to an overall improvement in well-being among parturient women and newborns. In a comparative evaluation of the *Rede Cegonha* program, Leal et al.[25] showed that the participation of obstetric nurses/midwives in vaginal childbirth care increased from 15% to 30% between 2011 and 2017. In other words, normal-risk births can be conducted by qualified nurses with absolute assurance of quality. Unfortunately, this fact is still far from being recognized and accepted by a significant part of the Brazilian population, highlighting the need for educational campaigns. Some of the puerperal women acknowledged the importance of the work of obstetric nurses:

- I am grateful to the nurse who did my delivery. 10 out of 10!.

- I was really well cared for by the nurse who did my delivery. She gave a lot of attention. She supported me and we even had fun, cos she saw I didn't have a companion and stayed with me the whole time.

Presence of a companion

Another issue raised by some puerperal women was the presence of companions in maternity facilities:

- I would have been much calmer when I had the anesthetic if I had had a companion close by holding my hand and giving me support.

- I would have liked to have had companion the whole time.

Despite these and other complaints, Leal et al.[25] point out that important advances have been made in this direction since the creation of the *Rede Cegonha*, showing that the presence of a companions during childbirth increased by over 150% between 2011 and 2017. Some of the interviewees confirmed this change for the better:

- This maternity facility has improved a lot and this business of having a companion was the best thing. My companion helped me a lot.

- This time I felt I was treated better. It's my third child; all of them were born in this maternity facility. In the others they didn't allow a companion during the birth.

The WHO explicitly recommends that women should have a companion of choice during childbirth and suggests that the presence of a companion is directly associated with ensuring the provision of respectful, competent and caring maternity care services[34].

The sensitive experience of giving birth alludes to the desired type of family relationship. Being in the company of someone who shares the emotion of childbirth helps women cope with the pressures arising from the bureaucratic, technocratic and impersonal logic common to hospital services. The presence of a companion represents a bond with the "before" the hospital, helping the pregnant woman situate childbirth in her life story. When together, puerperal women derive a sense of security from being able to count on the support of someone who feels at greater liberty to call the nursing staff if need be and provides protection against mistreatment[35].

Friends and family are an important source of support during exposure in a public setting and in dealing with the unknown and uncontrollable. The presence of a companion in public maternity facilities relativizes or even circumvents impersonal logic. Companions help to share feelings and sensitive life experiences.

Furthermore, parturient and puerperal women have a legal right to have a companion during labor, birth and the postpartum period[36].

Quality of hospital services and facilities

Some of the opinions in this category relate to lack of hospital facilities and lack of privacy of puerperal women and companions:

- *There were only two showers and one had a blocked drain*.

- *There were no sheets*.

- *I think the wards could have curtains between the beds*.

- (The hospital) *needs to improve the facilities for companions, offer breakfast, a bathroom where they can have a shower and a comfy chair to rest in*.

In a similar vein, the lack of/poor quality of meals in maternity facilities was also a cause of tension among some interviewees:

- *The nutrition doesn't consider breastfeeding, because all the meals are really dry*.

- *The food wasn't enough, I was hungry*.

In short, these complaints relate to demands for facilities and services that satisfy the needs of puerperal women and their companions. The space of the maternity facility is idealized as a place that should be equipped to ensure privacy and provide for every day needs such as food, personal hygiene and rest. In some ways, women expect a temporary "home from home" and lack of acceptance arises when, for example, the taps and showers fail to work, hospital food is insufficient, and there are no bed sheets. It is these and other aspects of hospital facilities that ensure puerperal women and their companions a place to "co-exist" in with dignity.

In this regard, in a study analyzing the degree of implementation of the *Rede Cegonha*, Bittencourt et al.[6] did not find an entirely promising situation in relation to hospital services and facilities. Their findings show that maternity facilities were in different stages of implementation, reflecting regional inequalities in socioeconomic development.

It is important to note however that it is not always clear from the criticisms of the hospital services and facilities made by the interviewees whether the complaints were fruit of neglect by health professionals, poor management, or lack of resources. Furthermore, all of the complaints were found alongside comments praising the SUS, with the puerperal women showing that they were well impressed with the service in general, contrary, not surprisingly, to the reductionist common belief that discredits efforts to universalize public health in Brazil and humanize childbirth. Compliments predominate over criticism in the accounts of the puerperal women, accounting for 50.5% of all comments. Examples abound:

- *I was scared of being admitted to this hospital because it is public. But I had a pleasant surprise because I am being very well looked after. The food is good, the place is clean and the team is nice*.

- *It exceeded my expectations! I was apprehensive about using the SUS and being mistreated, but I was surprised by the standard of service*.

- *I was very well treated, I have private health insurance but I used the SUS*.

The compliments corroborate the findings of Leal et al.[25], who observed advances in obstetric care indicators after the creation of the *Rede Cegonha*, a strategy that involves the consolidation of a family planning and prenatal care culture, including the creation of residency programs and specialist training in women's health, with specific courses on nursing, participatory management and hospital inspection. The findings showed a number of significant improvements between 2011 and 2017, the year that marked the seventh anniversary of the program: a substantial increase in the rate of vaginal deliveries; increased presence of companions of choice in maternity facilities; a rise in the use of non-pharmacological pain relief methods; and greater freedom of movement throughout labor. In other words, despite the urgent challenges facing the SUS, the quality of labor and childbirth care in Brazil is undergoing a process of change for the better, driven by initiatives to enhance Brazil's health model. In the words of the puerperal women:

- *The maternity services are getting better and better*.

- *In comparison to previous deliveries, the service was excellent*.

- *I loved the service compared with my other delivery 21 years ago, when I suffered all kinds of embarrassing situations*.

- *During the birth of my oldest child, Yasmin, seven years ago, I was mistreated. Today it's much better. They let you stay in a sitting position, help you bath the baby. They give you much more attention now*.

Final considerations

The views of puerperal women reported here depict their lived experiences, providing important

insights into the standard of care in public maternity facilities in Brazil. These personal opinions help identify priorities and develop solutions to collective problems. This article focused on this source of experience, observing what it reveals about approaches to women's health care, be they good or harmful to the exercise of citizenship. Without any pretense of providing definitive answers, our aim is to contribute to the flow of transformative knowledge.

One important lesson found throughout the comments analyzed by this study is that the justifications for the satisfaction or dissatisfaction of the puerperal women in some way reiterate the relevance of the social struggle for humanized childbirth in this country. The satisfaction expressed by the women demonstrates the existence of a public care service that guarantees women the right to humanized care in the childbirth process and postpartum period, while the dissatisfaction reinforces the importance of strengthening and stepping up efforts to improve the quality of care. Maternity facilities are idealized as a space that welcomes women, their families and newborn babies. In their own different ways, these women demonstrate that childbirth should not be seen as merely technical event, as summed up by the following comment: "I'd say that doctors need to deliver increasingly humanized care".

The humanization of childbirth is about the provision of quality care in which pregnant, parturient and puerperal women are at the center of the birth process. It is about the right of these women to be kept well informed, make decisions about their own body, pregnancy and childbirth, and be heard.

From this perspective, it is important to recognize that the policies and actions implemented by the Ministry of Health and embodied in the *Rede Cegonha* are on the right track, effectively promoting auspicious changes to labor and childbirth care processes and leading to a reduction in adverse maternal and neonatal outcomes. These actions should be valued and intensified through the orchestrated structuring of the care services delivered by the SUS. In addition to public debate and campaigns, the challenge of universalizing humanized childbirth in Brazil involves the consolidation of institutional arrangements in the field of reproductive health. More than a fleeting demand that benefits society, the improvement of policies aimed at humanizing childbirth is a social right social and a duty of the State.

Collaborations

NP Leal was responsible for study conception and design, data interpretation, and writing and critically revising this article, and approved the final version to be published. MH Versiani participated in study conception and design and data interpretation, made a substantial contribution to the writing of this article, and approved the final version to be published. MC Leal participated in study conception and design, data collection and interpretation, in writing and critically revising this article, and approved the final version to be published. YRP Santos contributed to the analysis and interpretation of results and writing of this article, and approved the final version to be published.

References

1. Brenes AC. História da parturição no Brasil, século XIX. *Cad Saude Publica* 1991; 7(2):135-149.
2. Palharini LA, Figueirôa SF. Gênero, história e medicalização do parto: a exposição "Mulheres e práticas de saúde". *História, Ciências, Saúde-Manguinhos* 2018; 25(4):1039-1061.
3. Coelho FE. A História das Ciências e seus públicos. *Revista Maracanan* 2015; 13(1):23-33.
4. Silva F, Nucci M, Nakano AR, Teixeira L. "Parto ideal": medicalização e construção de uma roteirização da assistência ao parto hospitalar no Brasil em meados do século XX. *Saúde Soc* 2019; 28(3):171-184.
5. Nakano AR, Bonan C, Teixeira LA. Cesárea, aperfeiçoando a técnica e normatizando a prática. *História, Ciências, Saúde – Manguinhos* 2016; 23(1):155-172.
6. Bittencourt SDA, Vilela MEA, Oliveira MC, Santos AM, Silva CKRT, Domingues R, Reis AC, Santos GL. Atenção ao parto e nascimento em maternidades da Rede Cegonha: avaliação do grau de implantação das ações. *Cad Saude Publica* 2020; [no prelo].
7. Nakano A. A normalização da cesárea como modo de nascer: cultura material do parto em maternidades privadas no Sudeste do Brasil. *Physis* 2015; 25(3):885-904.
8. World Health Organization (WHO). Appropriate technology for birth. *Lancet* 1985; 24(2):436-437.
9. Leal MC, Szwarcwald CL, Almeida PVB, Aquino EML, Barreto ML, Barros F, Victora C. Saúde reprodutiva, materna, neonatal e infantil nos 30 anos do Sistema Único de Saúde (SUS). *Cien Saude Colet* 2018; 23(6):1915-1928.
10. Brasil. Portaria nº 1.459, de 24 junho de 2011. Institui, no âmbito do Sistema Único de Saúde - SUS - a Rede Cegonha. *Diário Oficial da União* 2011; 24 jun.
11. Marques CPC, organizador. *Redes de Atenção à Saúde: A Rede Cegonha*. São Luís: Universidade Federal do Maranhão; 2015.
12. Brasil. Ministério da Saúde (MS). *Implantação das Redes de Atenção à Saúde e Outras Estratégias da SAS*. Brasília: MS; 2014.
13. Brasil. Ministério da Saúde (MS). *Rede Cegonha*: *Panortama*, 2017. [acessado 2020 Maio 4]. Disponível em: https://www.saude.gov.br/acoes-e-programas/rede-cegonha/panorama
14. Brasil. Ministério da Saúde (MS). *Rede Cegonha*. [acessado 2020 Maio 6]. Disponível em: https://www.saude.gov.br/acoes-e-programas/rede-cegonha
15. Vilela MEA, Leal MC, Thomaz EBAF, Gomes MASM, Bittencourt SDA, Gama SGN, Silva LBRAA, Lamy ZC. Avaliação da atenção ao parto e nascimento nas maternidades da Rede Cegonha: os caminhos metodológicos. *Cien Saude Colet* 2020; 26(3):789-800.
16. Gomide MFS, Pinto IC, Bulgarelli AF, Santos ALP, Serrano Gallardo MP. A satisfação do usuário com a atenção primária à saúde: uma análise do acesso e acolhimento. *Interface (Botucatu)* 2018; 22(65):387-398.
17. Gabe MB, Rosa AS, Garcia LSB, Ambrosio PG, Madeira K. O grau de satisfação do usuário é um importante indicador na avaliação da qualidade dos serviços de saúde. *Arquivos Caterinenses de Medicina* 2018; 47(3):146-158.

18. Esperidião MA, Vieira-da-Silva LM. A satisfação do usuário na avaliação de serviços de saúde: ensaio sobre a imposição de problemática. *Saúde Debate* 2018; 42(n. esp. 2):331-340.
19. Brasil. Ministério da Saúde (MS). *Princípios do SUS*. Portal do Ministério da Saúde. [acessado 2019 Dez 9]. Disponível em: https://www.saude.gov.br/sistema-unico-de-saude/principios-do-sus
20. Bardin L. *Análise de conteúdo.* Lisboa: Edições 70; 1979.
21. Silva AH, Fossá MIT. Análise de conteúdo: exemplo de aplicação da técnica para análise de dados qualitativos. *Qualitas* 2015; 17:1-14.
22. Oliveira VJ, Penna CM. Cada parto é uma história: processo de escolha da via de parto, Brasília. *Rev Bras Enferm* 2018; 71(Supl. 3):1304-1312.
23. Pimentel TA, Oliveira-filho EC. Fatores que influenciam na escolha da via de parto cirúrgico: uma revisão bibliográfica. *Universitas* 2016; 12(12):187-199.
24. Baldisserotto ML. *Associação entre as boas práticas de assistência ao trabalho de parto e parto e a avaliação pelas puérperas do cuidado recebido* [dissertação]. Rio de Janeiro: Escola Nacional de Saúde Pública Sergio Arouca; 2015.
25. Leal MC, Bittencourt SA, Esteves-Pereira AP, Ayres BVS, Silva LBRAA, Thomaz EBAF, Lamy ZC, Nakamura-Pereira M, Torres JA, Gama SGN, Domingues RMSM, Vilela MEA. Avanços na assistência ao parto no Brasil: resultados preliminares de dois estudos avaliativos. *Cad Saude Publica* 2019; 35(7):1-14.
26. Socorro TC, Matos AO, Machado JBH. A violência obstétrica como afronta ao princípio da dignidade da pessoa humana e a necessidade de implementação de políticas públicas específicas no Brasil. *Anais do I Congresso Internacional de Direito Público dos Direitos Humanos e Políticas de Igualdade*, Maceió, Alagoas, 2018.
27. Kottwitz F, Gouveia H, Gonçalves A. Via de parto preferida por puérperas e suas motivações. *Escola Anna Nery* 2018; 22(1):1-8.
28. Arik R, Parada CMGL, Tonete VLP, Sleutjes FCM. Percepções e expectativas de gestantes sobre o tipo de parto. *Rev Bras Enferm* 2019; 72(3):46-54.
29. Nakamura-Pereira M, Leal MC, Esteves-Pereira AP, Domingues RMSM, Torres JA, Dias MAB, Moreira ME. Use of Robson classification to assess cesarean section rate in Brazil: the role of source of payment for childbirth. *Reproductive Health* 2016; 13(Supl. 3):245-265.
30. Esteves-Pereira AP, Deneux-Tharaux C, Nakamura -Pereira M, Saucedo M, Bouvier-Colle MH, Leal MC. Caesarean Delivery and Postpartum Maternal Mortality: A Population-Based Case Control Study in Brazil. *Plos One* 2016; 11(4):1-13.
31. Martinelli KG. Idade materna avançada e sua associação com placenta prévia e deslocamento placentário: uma metanálise. *Cad Saude Publica* 2018; 34(2):1-14.
32. Varela AR, Schneider BC, Bubach S, Silveira MF, Bertoldi AD, Duarte LSM, Menezes AMB, Domingues MR, Bassani DG. Mortalidade fetal, neonatal e pós-neonatal e fatores associados na coorte de nascimentos de 2015 de Pelotas, Rio Grande do Sul, Brasil. *Cad Saude Publica* 2019; 35(7):1-15.
33. Gama SGN, Viellas EF, Medina ET, Angulo-Tuesta A, Silva CKRT, Silva SD, Santos YRP, Esteves-Pereira AP. Atenção ao parto por enfermeira obstétrica em maternidades vinculadas à Rede Cegonha. *Cien Saude Colet* 2021; 26(3):919-929.
34. Organização Mundial da Saúde (OMS). *Prevenção e eliminação de abusos, desrespeito e maus-tratos durante o parto em instituições de saúde, 2014*. [acessado 2019 Dez 1]. Disponível em: https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_por.pdf;jsessionid=6B8C2C3FEF468BA496DD07082ABB4266?sequence=3
35. Zanardo G, Uribe MC, Nadal AHR, Habigzang LF. Violência Obstétrica no Brasil: Uma revisão narrativa. *Psicologia & Sociedade* 2017; 29:e155043.
36. Brasil. Lei nº 11.108, de 7 de abril de 2005. Altera a Lei nº 8.080, de 19 de setembro de 1990, para garantir às parturientes o direito à presença de acompanhante durante o trabalho de parto, parto e pós-parto imediato, no âmbito do Sistema Único de Saúde - SUS. *Diário Oficial da União* 2005; 8 abr.

Article submitted 19/03/2020
Approved 11/06/2020
Final version presented 13/06/2020

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva