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## Care from the perspective of midwives from the Amazon: a descriptive study

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### ABSTRACT

**Problem:** geography and difficulty of access to health care contribute to maternal and neonatal mortality in the North and Northeast of Brazil. **Aim:** to identify the care arrangements used during labor and birth by midwives from the Amazon. **Method:** 15 midwives from the cities of Manaus and of Vila de Lindoia/Itacoatiara region took part in two focus groups held between December 2015 and March 2016. Data analysis focused on three cores of meaning and the use of narratives. **Results:** most of the arrangements designed to assist women occurred in cities in the inner regions of the state of Amazonas, Brazil. The midwives' narratives were based around three core sets of meanings: Complicity and Recognition; Midwife Memories, and Labor and Birth. **Conclusion:** midwives build a logic for care centered around women. It is an extensive and creative practice, available to sustain life during and after the birth.

**Descriptors:** Midwives, Practical; Humanizing Delivery; Maternal Mortality; Amazonian Ecosystem.

## INTRODUCTION

High rates of mother and neonatal mortality are a persistent health problem in Brazil. In the Northern and Northeastern regions of the country there are particularly negative outcomes, explained primarily by the “health care gaps” existing in those areas<sup>(1)</sup>.

Within the context of the thematic networks of health care agenda, the *Rede Cegonha* (RC, or *Stork Network*, in English)<sup>(2)</sup> was designed to guarantee greater access to, and provision of, health care: besides reducing maternal-child mortality in children up to two years old (with a particular emphasis on neonatal mortality), it is a political strategy designed to implement a strong model of maternal-child care<sup>(2)</sup>.

In this study, midwives were the focus of the investigation, as they have been an important component of the increasing humanization of birth and labor practices since the year 2000. This has occurred through the *Working with Traditional Midwives Program*<sup>(3)</sup> under the Technical Area of Women’s Health – Brazilian Ministry of Health (MS, in Portuguese), in a partnership with the NGO *Curumim Gestaçao e Parto* (Curumim Gestation and Labor, in English). It is a program that draws on a wealth of experiences and is a reference to the singularity of the Northern and Northeastern regions of Brazil, who offer an effective strategy to reduce maternal and neonatal morbid-mortality rates through the education of traditional midwives, preparing them for home labor.

In the Brazilian state of Amazonas, midwives are enrolled into the Rede Cegonha, the objective being to strengthen the reduction of maternal and neonatal mortality through their links with Family Health Strategy teams. With the introduction of formats that are ever adapting, new investments in awareness and training have been made since 2009 by the management

structure of the technical area of women’s health; this was supported by the Brazilian Ministry of Health who aimed to purchase specific resources for the work of midwives<sup>(4)</sup>. Basic Care has an important role in operating the resources along with the setup in which it will be used.

There is still much to be done in terms of goals established and the agenda built by the managers and professionals if the role of midwives is to be recognized<sup>(5)</sup>. Yet they are important politically, as they have access to technologies and techniques that are able to alleviate pain and discomfort, as well as being the link that can generate trust and care when working to protect lives.

This article describes a national research project entitled “National Observatory for the Production of Care in Different Modalities under the Light of the Process of Implementation of Thematic Networks of Health Care in the Brazilian Unified Health System: evaluation by the one who orders it, who does it, and who uses it”. It was coordinated<sup>(3)</sup> by the Rio de Janeiro Federal University in cooperation with the Fluminense Federal University, and carried out by the Study and Research Center in Management and Work in Health in conjunction with a number of other higher education institutions. This text focuses on midwives from the Northern region of Brazil, and aims to identify the nature of the care procedures used by midwives during labor and birth. Arrangements here are understood as artifices, originating from cultural, technical, and relational backgrounds, and used in the process of assisted birth by Amazon midwives.

## METHOD

This qualitative study will explore the practical experiences of midwives. It is part of an umbrella project recognized as part of the

*Rede de Avaliação Compartilhada* (RAC, or Shared Evaluation Network, in English) University – SUS (Brazilian Unified Health System). It follows the ethical guidelines for research with human beings, outlined in the Resolution #466/12 of the Brazilian National Health Council. It was approved by the Committee of Ethics under protocol #876.385/2014.

The technique for data collection used in the investigation was that of focus groups (FG)<sup>(6)</sup> which aimed to explore, through dialogue, both individual and shared perspectives. In this study, the FG was developed according to the following steps<sup>(6)</sup>: 1. Definition of participants; 2. Contact with the members to clarify the invitation; 3. Conveyance of location and date; 4. Definition of triggering questions; 5. Setting up the environment.

The focus group schedule was based on the logic of designing a conversation wheel, framed within a welcoming environment<sup>(7)</sup> designed to induce the midwives' narrative testimony. The resulting narratives call attention to the experiences of midwives<sup>(8)</sup> as they outline and demonstrate the arrangements and means of care they utilize to assist women during labor and birth.

The population sample comprised eighty-six midwives from Manaus and Itacoatiara, two priority municipalities in the RC program; the professionals were already enrolled in the Technical Area of Women's Health in the Amazonas' State Health Department. Fifteen midwives from this sample participated in the investigation, an appropriate number given the criteria for saturation in a qualitative study<sup>(7)</sup>. The criteria for selection chosen by the researchers were that participants should be either a resident from Vila de Lindóia, Itacoatiara, or peripheral areas of Manaus; they should be nominated by other health professionals, or other midwives; they should have at least three years of experience and recognize themselves as a midwife (or at

least with experience as a midwife). The criteria for exclusion were: being an exclusive midwife in indigenous communities; having a profile under Amazona's State Health Department which was outdated or expired. The participants signed a consent agreement after they were told the purpose of the research. This informed them of its goals and affirmed their testimonies were going to be rendered anonymous.

There were two Focus Groups in total<sup>(7)</sup>, one took place in December 2015, and the other in March 2016; these comprised nine and six participants respectively and both lasted two hours. A moderator, who was also a researcher with previous experience in focus groups, facilitated the groups and aimed to direct as little as possible so that the midwives did not feel inhibited when they took part<sup>(7)</sup>.

Four assistant researchers were also present to observe the conduct of the groups and take notes on the process. In order to guarantee the anonymity of the testimonies, midwives were not identified by name but were instead labelled using the names of roses and flowers (as suggested by one of the midwives).

The work with the FG<sup>(6)</sup> comprised Stage II of the method (Stage I was the invitation; Stage II was the FG meeting; Stage III was the transcription). During the group objects related to care practices used during labor and birth were present – some were brought by the midwives, and others by the researcher. All were made available to decorate the scenario: a large white voile curtain, colored tablecloth, a rocking chair placed in a central position and covered by a patchwork blanket, all with surrounding carpets. The setup was designed to help to provide a welcoming environment in the space used and was located inside the Municipal School of Vila de Lindóia.

The rationale for this was that the objects worked as covenants of memories and provoked the opinions of the participants about their own

process of care. The discourses elicited were interwoven with moments of relaxation, and local folk dancing and singing.

Some representatives of the local community also participated in the overall dynamics as observers, at the request of the participant midwives. They were either relatives, institutional actors who were also from the city central area, or representatives of social movements. Analysis of the material showed there to be a combination of sources and narratives present; the intention was not to organize this material in order of relevance, but to see them as a fabric built and experienced and made through the discursive possibilities that were in place, thus generating three core sets of feelings: Complicity and Recognition; Memories of the Midwife; and Labor and Birth. The narratives emerging from each midwife flowed through different sets of feelings and paths of logic, due to the fact they were built in meetings in a relationship each participant had with togetherness and their own internal processes<sup>(9)</sup>, processes that question what is happening in institutions, in respect of the guidelines which illuminate and highlight the midwives' care practices.

The narratives were therefore not only a product of individual experiences, they were a dialogic activity situated within a shared cultural context

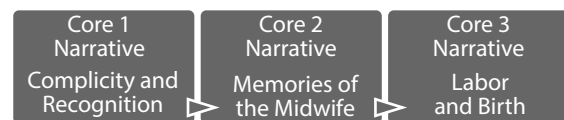
## RESULTS

The 15 midwives who took part in the research were from municipalities of the Brazilian states of Pará and Amazonas, they are or were married, were between 47 and 83 years old, and have participated in 20 to 1,250 labor processes. Their professional knowledge was transmitted to them by their mothers or another person from their life. Most of the arrangements set to assist

women took place in cities far from the capital of Amazonas.

The findings of the narratives were grouped around core sets of feelings as represented in Image 1, below.

**Image 1.** Core of feelings generated from the analysis of the narratives of focal groups. Brazil, 2015-2016.



Source: research data.

### *Narrative Complicity and Recognition*

This core presents narratives as a dynamic of interpersonal and social interaction. These are processes of self-affirmation of the work as midwife which is reciprocal, and are the means by which participants become involved in the task of self-recognition.

Many times we were rejected and today things are changing due to humanization. (midwife Desert Rose).

The construction of recognition of the work is attributed to complicity among the midwives:

"We are always in partnership, always looking for anonymous midwives, so they are not left behind." (midwife Desert Rose).

Here we can call attention to the effort to maintain the tradition of a practice that supports the development of life, once midwifery is present it is strongly linked to respect, and is a universal sign of recognition. This can be observed in a narrative which occurred during the

group meeting, when one of the midwives made a reference to the midwife Jasmin, who helped her during the birth of her grandson.

Recognition, as a build element present in the everyday life of the midwives, demonstrates clearly the implications for their work, a practice intertwined with many challenges and harsh conditions. The implication emerges in relation to social policies and constructions:

When we arrive in that community, and [the midwife] Desert Flower knows that... they didn't have piped water... many times I had to work using a lantern from a fisherman... placing it in my mouth so I could investigate... natural delivery is natural, but there are some that are hard – each labor process is a little surprise box... today... we remembered to use a lantern. (midwife Desert Rose).

In many cities in the Northern region of Brazil, getting access to electricity and basic sewage treatment and thus guaranteeing people's basic rights is a challenge and a daily struggle. In the narrative of the midwives, it is linked to the necessity for electric lighting to assist mothers in labor.

Many of the deliveries we give attention, love... The first delivery I participated was also under the light of a oil lamp, but everything went fine. (midwife Hydrangea)

Complicity and recognition go together in the narrative of the midwives. It is a complicity built and nurtured by friendship, and by the recognition of the work and the performance of the midwives in assisting labor processes.

The first labor I participated was of twins, in a colleague. I was saying "mom, now I am removing the placenta". (midwife Bromeliads)

The space built by complicity does not recognize limits, and it occurs when birth calls – at the house of the midwife, of the mother, or any other place, as the feelings and sensations of the midwife are built around happiness and satisfaction.

I am quite known in Lindóia... I help to deliver since I was 35 years old... The first delivery was in the daughter of a woman called Mrs. B; she went to my house, far from town... Since 1975 I was living there... I took the child and she delivered in my house. It was really good; I was satisfied with the outcome. (midwife Jasmine).

The feeling of the midwife is a feeling of an unlimited joy because you see life coming to this world. (midwife Lotus Flower).

To recognize oneself as a midwife is to be associated with practical experiences in the narrative, but also as having a "gift", something built into their family dynamic, and in the community in which they live. For them, midwifery is a mission given by God, and because of that they understand that He is also at their side in difficult moments as can be seen in the narratives below.

I am not a certified midwife [meaning there was no official training]; I would do it when it was needed, when people needed me. (midwife Bromeliads).

I didn't learn it with anyone... I was God who has given me this gift. My mother was a midwife, but I never helped her in any delivery... I used to go with her to see it... She used to ask me to do some things... But I didn't know anything. (midwife Orchid).

The implied links to human existence and solidarity underpins a constant movement in building up the process of work/care of the midwife. It is an edifying action within the space designed to support labor and birth.

In the city, my mother was the construction of a delivery home, which welcomed women that came from far and from town who didn't want to go to the hospital, and there they had their babies and were assisted until they could go home. (midwife Desert Rose).

### *Narrative Memories of a Midwife*

In the first core set of feelings, it was possible to explore the relationship between recognition and complicity of the midwives with their work and care in labor practices. This second set concentrates on the feelings within the memories of these women.

The narrative below expresses key dialogue between the midwives:

Thank to God all my delivery children are alive... I love to do this work... It's not because I want to take someone's place... Women have some happiness and some sadness because they know how painful is to have a child, but when the baby is born is a joyful moment for

the parents and for the midwife as well (midwife Lotus Flower).

I am a mother who came from a humble family, from the countryside of the state of Pará, whose grandmother was a midwife and caregiver, and my mother inherited this gift. I had it as a legacy, always accompanying my mother since I was 12 years old. She used to take me to follow her when there was someone needing her in a far place. And in town it wasn't different, because every time I could I was with her, as we were 13 children, but I was the only girl. (midwife Desert Rose).

These are stories of a transmitted care practice, sometimes from generation to generation, mixed with religious elements.

The care practices narrated by the midwives are the results of an active, attentive, carer, an accomplice in the process:

When the mother is weak, I prepare a charity soup, with garlic and black pepper, for her to feel better. A warm cup of milk with salt and butter. That will give her some strength... And in a short time she will feel the delivery pains. (midwife Bromeliad).

I bring many children – if the person needs me, I'm there to help. I am not [a certified] midwife, I cannot afford to stay in a clinic. I once assisted deliveries, together with E. in a clinic, but if someone asks for my help, I'll be there. (midwife Hydrangea).

Midwifery learning begins in different ways, sometimes together with the mother (or

another relative) while they are still children. The narratives relate how midwives as professionals emerge.

When I was 13 and my sister was born, I didn't know how to cut the cord, and when the time came, my mother called me. After that, I assisted many, many labors, but this is not my profession (midwife Black Prince).

My first delivery was of my granddaughter (midwife Orchid).

Furthermore, relationships built in the community and the construction of new, affectionate bonds of support help to develop midwifery:

Through the midwife Rose I was interested, because in my family there are no midwives, and I even asked my mother about it. (midwife Daisy).

My mother was a midwife, also my great-grandmother. Her mother started assisting labors at the age of 11, but when she lost her mother, she moved out to live with a person who performed cures, a person who assisted deliveries. (midwife Lotus Flower).

I assisted my first delivery when I was 16 years old, in Manaus, near a bayou... when I was called the mother was already having the baby (midwife Orchid).

The stories of midwives are intense. They originate from meetings that generate the means through which they are produced and comprise a collective process of construction. This also indicates the engenderment of the relationship between the knowledge of the

midwife and health service, research, and education institutions:

I already knew S, who had organized through the State Health Department (SUSAM) and others – such as the Curumim Group – a meeting of midwives and was present in some other events. One day, S called me and said she was coming to visit the community. And with her there were A and L. they invited us for a conference at the Amazonas Federal University (UFAM), and there we shared our knowledge among midwives from distant cities, from the capital, and there was one from the state of Pará – all with the gift of providing care and midwifery. (midwife Desert Rose)

We had a meeting in Vila de Lindóia, in December 18th 2015, "The Tale of the Midwives", organized by us, the Shared Evaluation Network in Amazonas, in which today I take part, together with midwives from my community, Vila de Lindóia, and we were very happy for that opportunity. (midwife Desert Rose)

We were extremely satisfied with the collaboration and support from the staff of the Ivo Amazonense de Moura School and its headmaster. I cannot forget to mention A, the social worker and UFRJ researcher, who together with the physician B and other who helped us, such as S, from women's health at the SUSAM, so this event could take place. We had the presence of a journalist from Itacoatiara, a nurse from the José Mendes Hospital, also from Itacoatiara,

professionals from the Basic Health Unit of Lindóia, and the presence of partners of Movement for Peasant Women. I was really happy, as a midwife, to be part of this gathering, which was wonderful. (midwife Desert Rose)

### *Narrative of Labor and Birth*

The narratives highlighted in this core set of feelings elaborate on the means of care the midwives use during the whole process of labor until birth. There are management procedures and arrangements to support women, all of which are produced from the very first sign of labor. The core dynamic is always produced by the midwife who considers the mother as the center of her activities. Therefore, the desires and choices of the parturient are primary and the management of the midwife focuses on using tools (e.g., candles) as technologies to assist them.

For example, the midwife Lily affirms in relating her testimony, that:

If it is to speak out, I'll do it, then. I helped in many deliveries, with and without electric lighting from this woman here... she has 4 children [showing an old, yellowish notebook], she had no light, she bought a dozen of candles, and when the time the baby was suppose to come, and the candles all lighten up... the baby girl was 4.150 kg [9.1 lb.]... everything went fine, the child was born, the child was ok, mother too, and this is my story... [to weight the child she demonstrates the scale she used] The hammock I designed to weight the child was this one, I created this design. When a child was born, I

would place the baby on the bed and placed him there, without hurting the baby. And there is more... when I was going to assist a labor procedure... I used to take notes.

The arrangements of midwifery are produced according to movements in labor. The oils used are in accordance with the evaluation of the midwife and arise from an interaction and bond between the professional and the mother.

When the time comes for the labor procedure, the child comes; when there is not enough space, I use some oil... It won't open for all mothers. (midwife Bromeliad)

Later... Two girls on the road... This woman, she didn't have electricity at home, which was inside an arm of the river, very far, about 4 km [2.5 mi] to arrive... They were very poor, house placed on dirt land... they didn't even have flooring inside, she already had five kids, and she had two more when I was there... she called me and asked: can you help me deliver? I like encourage people, as people used to do with me. Suddenly she started to feel the pains from labor. It was pain here and there, but the babies didn't come out... I remembered the tea with only three seeds of coffee. When there is no coffee available, we use chicory roots for the tea, and spread some alcohol or butter on the belly of the mother... on the stomach of the woman... When the first came it was a baby girl, but the cord was wrapped around the neck... Together with the sac... She came with the sac... What could I have done?...



I got the skin of a garlic clove and I cut it... she came, but the cord was from the other baby wrapped around her neck... I found a way... And I was embarrassed and praying... And thank God the first child was born, and three or four minutes later the second also came. They were sharing the same placenta... I believe there children are around 20 years old today. (midwife Lotus Flower)

An intense life was about to be presented, therefore in every dialogue there was something for them to be updated about, building between the participants a relationship of togetherness.

## DISCUSSION

The midwives were presenting new points of view – and views from their own standpoint<sup>(10)</sup> about the production of care, the transit through the instituted care network and/or out of it (and even “between” these spaces of conformation).

The arrangement of networks in Lindóia, Vila de Itacoatiara, show an intensive production in a place typically characterized as having a “care assisting gap”, but is now understood as having a new ethos of care, better technological arrangements, and fulfillments that support both labor and birth.

Regarding the first core set of feelings, these highlighted the asymmetrical and symmetrical relationships between recognition of their role<sup>(11)</sup> by the midwives, and the institutionalization of the Brazilian National Policy for Humanization (PNH) of the Brazilian Ministry of Health.

One of the goals of the PNH consists of strengthening existing humanization initiatives, making them visible through the setup of a live network with elements that characterize a mix

of satisfaction and tension, strength, courage, and creative action.

Within the context of PNH, the possibility of increasing the safety of women during the process of labor and puerperal during motherhood would decrease the feeling of fragility and loneliness which is secured by the statutory presence of an accompanying individual<sup>(12)</sup>. There is recognition of the need for support and help for both the mother and the baby, and the compositions of networks that surround the midwives in their modes of care.

The arrangements of the midwives require interaction which occurs in multiple ways, such as through social life, and in getting along with other practices<sup>(13)</sup>. In Lindóia, sometimes this involves relatives, neighbors, other midwives, professionals, and members of the community. These are the connection networks that are used in midwifery.

Midwives share a common moral value, one that recognizes human life as resulting from a care action nurtured by the desire to continue the human existence for as long as possible<sup>(14)</sup>.

The second core set of feelings comprises narratives based around the knowledge produced in the act of delivering. It is through this experience that the midwives acquire the techniques and procedures to assist the mother and the baby. In the most complicated cases they rely on folk beliefs passed on from generation to generation<sup>(15)</sup>.

The third core set of narratives shows birth as a happening<sup>(16)</sup>. For example, delivery as a happening ensures that, based on the concrete situation, there is room for care in the counter-effect of the birth where there are multiple spaces and arrangements of objects.

During the presented narrative, three objects were chosen the most: the oil lamp, associated with lightning; a small hammock to weigh children, associated with care; and the midwife

booklet, linked to the registries (in which many times only the living memory can witness). Other associated elements are: the tweezers, scissors, gauze, cord, gloves, clean cloths, herbs, and massage oils, all used according to the situation and ease of access. However, it is important to mention that the arrangements used by the midwives in the Amazon during pregnancy, labor, and birth are in some ways ahead of the hard technological equipment needed during labor.

Studies have shown that spontaneous labor<sup>(17)</sup> is a privilege for both the mother and the baby, not only during the procedure, but also throughout their whole lives. A physiological labor procedure, when well performed, permits a respectful and safe environment, and generate and supports bonds between the mother and the baby that can also be seen during breastfeeding.

The singularity of the context observed is expressed many times by the “Amazon factor” – low population density, health care gaps, geographical barriers such as rivers and lakes, river ebbs and flows – it is seen here as a conceptual operator that opens up sanitary gaps and continuities, as well as helping to problematize the understanding of the organization of health care services and the networks that manage them. Considered in its most extreme form, there are geographical distances and roads – dirt and river ones – which are made by the midwives during the process of care, thus presenting another logic for the process of birth.

Such logic undoes the idea of the supremacy of scientific knowledge over common sense, because throughout the history of assisted labor there is probably no professional whose importance and representation is as great such as that of the midwife<sup>(14)</sup>.

Movements with midwives and the women assisted by them bring the support of life to its most radical position. The arrangements and

compositions that have been identified lead to the conclusion that validated understandings via scientific methods are currently suspended. This understanding permits us to affect and be affected by, the period waiting for the midwife to initiate the procedures, the responsibility towards the actions and values these women prioritize, and the recognition of their limitations. In addition, there is also the reassurance felt by comforting, pausing, strengthening, listening, touching, and the handling of traditionally transmitted knowledge. In centering the mother within the process, meaningful learning related to the procedure is itself prioritized, this occurs in tandem with a complicity that makes the difference in the processes of care. This opening, important and interesting in training, but not subscribed to in the logic of the health professions, can certainly help to provide better care.

## CONCLUSION

The midwives build a logic of care that not only includes the woman, it places her in the center of care, something that the policy for humanization and the strategy of the *Rede Cegonha* highlight as relevant in terms of reducing the rates of maternal and neonatal mortality.

The different birth environments and conditions do not offer a challenge, they offer experience in the management of mother/baby care. There are many unusual situations, happenings that reinforce the vigor, the power of life in the hands of the midwives.

It was observed that in the narratives the care networks related to labor and birth are built upon different formats and systems of logic, not just those instituted by public agents but also those by collectiveness, all in an extensive and creative practice of “giving a hand” and being available for life and birth.

This study would need to explore further the role of midwifery as a potential practice of care and life production; and where productive tensions lay around the instituted and the institute over the practices that involve women, labor, and birth. This will require new and deeper investigations, beyond those which have been presented thus far.

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