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Original Article

The influence of postpartum women's experiences related to labor and delivery

A influência das vivências de puérperas relacionadas ao trabalho de parto e parto

La influencia de las experiencias de las mujeres posparto relacionadas con el trabajo de parto y el parto

Cíntia de Souza Santana[1], Carolina Coutinho Costa Vallejos[2], Roselande Simon[2], Melissa Guterres Costa Lourenço[2], Adriane Maria Netto de Oliveira[2], Camila Daiane Silva[2]

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Corresponding author:
Carolina Coutinho Costa Vallejos. E-mail: coutinhocarolc@hotmail.com

ABSTRACT

Objective: To understand the influence of women's life history and experiences related to labor and delivery on birth outcomes. **Methodology:** A qualitative, exploratory, and descriptive study conducted in a teaching hospital in Southern Brazil with postpartum women with low-risk pregnancies who underwent vaginal labor and delivery. Exclusion criteria: cesarean section indicated during labor, complications, or absence of rooming-in postpartum. Data were collected through interviews and analyzed using content analysis according to Laurence Bardin. **Results:** It was observed that many postpartum women—even those with previous deliveries—are unaware of the physiological process of childbirth, do not receive adequate information during prenatal care, and do not seek to prepare themselves, demonstrating a lack of informational and emotional support. **Final Thoughts:** The lack of preparation and empowerment of women regarding the childbirth process is evident, implying the need for more humanized and educational care practices.

DESCRIPTORS:
Labor, Obstetric; Nursing; Obstetric Nursing.

[1] Hospital Universitário Miguel Riet Correa Jr. Rio Grande, Rio Grande do Sul, Brazil.
[2] Universidade Federal do Rio Grande. Rio Grande, Rio Grande do Sul, Brazil.

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RESUMO

Objetivo: Conhecer a influência da história de vida e vivências das mulheres, relativas ao trabalho de parto e parto, no desfecho do nascimento. **Metodologia:** Estudo qualitativo, exploratório e descritivo, realizado em hospital de ensino no Sul do Brasil, com puérperas de gestação de baixo risco que passaram por trabalho de parto e parto vaginal. Exclusão: cesárea indicada durante o trabalho de parto, intercorrências ou ausência de alojamento conjunto no pós-parto. Dados coletados por entrevistas e analisados pela Análise de Conteúdo segundo Laurence Bardin. **Resultados:** Observou-se que muitas puérperas, mesmo com partos anteriores, desconhecem o processo fisiológico do parto, não recebem informações adequadas no pré-natal e não buscam se preparar, o que demonstra ausência de apoio informativo e emocional. **Considerações Finais:** Evidencia-se a carência de preparo e empoderamento da mulher quanto ao processo de parto, implicando a necessidade de práticas de assistência mais humanizadas e educativas.

DESCRITORES:
Trabalho de Parto; Enfermagem; Enfermagem Obstétrica.

RESUMEN

Objetivo: Comprender la influencia de la historia de vida y las experiencias de las mujeres relacionadas con el parto y el nacimiento en los resultados del mismo. **Metodología:** Estudio cualitativo, exploratorio y descriptivo realizado en un hospital universitario del sur de Brasil con puérperas con embarazos de bajo riesgo que tuvieron parto vaginal. Criterios de exclusión: indicación de cesárea durante el parto, complicaciones o ausencia de alojamiento conjunto en el posparto. Los datos se recopilaron mediante entrevistas y se analizaron mediante análisis de contenido según Laurence Bardin. **Resultados:** Se observó que muchas puérperas, incluso aquellas con partos previos, desconocen el proceso fisiológico del parto, no reciben información adecuada durante la atención prenatal y no se preparan, lo que demuestra una falta de apoyo informativo y emocional. **Consideraciones Finales**: La falta de preparación y empoderamiento de las mujeres en relación con el proceso del parto es evidente, lo que implica la necesidad de prácticas de atención más humanizadas y educativas.

DESCRIPTORES:
Trabajo de Parto; Enfermería; Enfermería Obstétrica.

INTRODUCTION

Pregnancy and childbirth are identified as important physiological events in the life of a woman and/or a couple who wish to have a child. It is a time of transition in which the woman begins her maternal obligations while maintaining her personal and professional activities. During this phase, the pregnant woman experiences biological, psychological, emotional, and physical changes that can affect the physical and mental health of both the mother and the baby, as well as influencing the sociocultural context of the woman and her family[1-3].

During labor, the woman goes through different phases until birth, experiencing a series of determining factors, such as uterine contractions, cervical dilation, pain, fetal position and alignment, psychological preparation, and support from the health team throughout the entire process. During this period, physical and emotional vulnerability intensifies, which can affect the well-being of the woman and the child[1].

It is estimated that, worldwide, a woman dies every two seconds during childbirth. In 2020, approximately 2.4 million newborns died, although a large proportion of these outcomes could have been avoided with qualified assistance during pregnancy, labor, and the postpartum period[2-4].

Aiming to reduce maternal and infant mortality and improving care in the perinatal period, the World Health Organization (WHO) has incorporated the concept of "Positive Birth Experience" (EPP) into its guidelines. This experience involves the psychological preparation of the woman, the provision of an appropriate clinical environment, continuous support and follow-up by a competent and welcoming team[5]. The WHO reinforces that all pregnant women have the right to a respectful, safe and dignified birth, as well as their newborns[6].

When women experience a positive birth experience, there is a reduction in the fear of future pregnancies and a positive influence on other women in the community. Evidence suggests that self-efficacy in childbirth is a central element for postpartum self-efficacy, as it strengthens self-confidence, reduces maternal and neonatal complications, and enhances the pregnant woman's ability to cope with challenges during pregnancy, childbirth, breastfeeding, and initial newborn care[7].

On the other hand, negative experiences can compromise a woman's emotional well-being, favoring conditions such as postpartum depression and post-traumatic stress disorder. Such experiences can also harm the mother-baby bond, interfere with child development and generate conflicts in the marital relationship[8-9].

Although there are positive and negative experiences related to labor and delivery, there are still few studies that analyze how these experiences influence birth outcomes. Therefore, this study aims to understand the influence of women's life history and experiences related to labor and delivery on birth outcomes.

OBJECTIVE

To understand how women's life stories and experiences contribute to the construction of their perceptions and preparation for labor and delivery.

METHODOLOGY

Theoretical-methodological framework

This study is an excerpt from the master's dissertation entitled "Feelings and Experiences of Postpartum Women in Relation to Labor and Delivery," presenting part of the results obtained in the research. It is a qualitative, exploratory, and descriptive study, whose purpose is to deepen the knowledge about the subjectivity of women in relation to labor and delivery. Qualitative research seeks to analyze and interpret phenomena in a profound way, understanding them in the context in which they occur and favoring the description of human behavioral trends[10].

The qualitative study is characterized by investigating and analyzing events in their natural environment, observing the influences of the environment and recognizing that the simple quantification of data is not sufficient to answer the proposed questions[11].

Study type

This is a qualitative, exploratory, and descriptive study, developed from semi-structured interviews, with an interpretative approach to the data, based on Content Analysis.

Study scenery

The research was conducted at the Obstetrics Center of a University Hospital (C.O./H.U.), linked to the Federal University of Rio Grande until 2015, when it began to have shared management with the Brazilian Hospital Services Company (EBSERH). At the time of data collection (2018), the service was already under this management model.

Data source

Postpartum women who were admitted to the Obstetric Center in effective labor, characterized by regular contractions and/or cervical dilation equal to or greater than 5 cm, between July and September 2018, in the morning shift, were invited to participate in the study.

The inclusion criteria were: women aged 18 years or older, gestational age greater than or equal to 39 weeks, having completed six or more prenatal visits, according to the World Health Organization criteria for adequate prenatal care, and classified as having a low-risk pregnancy.

Women who experienced complications during the course of labor, who were indicated for cesarean section by the care team, or whose newborns did not remain in the same room were excluded. These criteria were adopted in order to limit the sample to women in low-risk conditions, allowing for the analysis of experiences and perceptions in the context of the physiological progression of labor.

Data collection and organization

Data collection was carried out through semi-structured interviews, containing closed and open questions, aimed at identifying socioeconomic conditions, gestational history, possible complications, the level of information about labor and delivery, and, above all, understanding experiences, thoughts, and feelings related to this process.

The interviews were conducted immediately after the fourth clinical stage of labor, a time when the postpartum woman was in a better position to calmly recount her experience, in accordance with the guidelines of the Research Ethics Committee in the Health Area (CEPAS) of the Federal University of Rio Grande (FURG).

Work steps

The study stages included: selection of participants according to established criteria; conducting interviews; full transcription of accounts; organization of empirical material; data analysis and categorization; and interpretation of results in light of the theoretical framework.

Data analysis

The data analysis was performed using the Content Analysis Technique, which favors the understanding of the relationships, meanings, and contexts involved in the investigated theme (6). The analysis followed the steps proposed by Bardin, comprising: (1) pre-analysis, with a floating reading of the material and organization of the corpus; (2) exploration of the material, with coding of the data and identification of units of meaning; and (3) treatment of the results and interpretation, with grouping of the codes into thematic categories. The categories were constructed inductively, based on the recurrence and relevance of the contents expressed in the participants' accounts.

The researcher observed the meanings expressed in the accounts, as well as the associated psychosocial, cultural, and environmental implications. After the analysis, the data were organized into analytical categories, which allowed for better visualization and understanding of the contents. In the present study, the categories made it possible to understand the experiences of postpartum women based on prenatal care, their own or close people's previous experiences, and the women's interest in seeking greater instrumentalization for childbirth.

Ethical aspects

To guarantee anonymity, participants were identified by the letter “P”, followed by the number corresponding to the order of the interview (e.g., P1). Fifteen postpartum women were interviewed, and data collection ended when data saturation was reached, characterized by the repetition of information. The study was approved by the Research Ethics Committee in the Health Area of FURG, under Opinion No. 91/2018 and CAAE 88871018.5.0000.5324, complying with the ethical guidelines for research with human beings, guaranteeing confidentiality, anonymity, and respect for the participants.

RESULTS

The sociodemographic characterization of the participants showed that the majority were women up to 25 years old, with completed high school education, self-declared white, without professional activity, in a stable relationship, and with a family income of up to three minimum wages. Regarding gestational history, the group consisted of five primiparous women (33%), eight participants with one previous pregnancy (53%), and two with two previous pregnancies (14%). Regarding parity, most women with previous pregnancies had experienced vaginal delivery. Among the seven participants in this condition,

two reported previous abortion and one mentioned a previous cesarean section.

Concerning prenatal care, ten participants received this care in the public primary care network (UBS, USF, or outpatient clinics), while five had consultations in private services or through health insurance. In the primary care network, they were followed by doctors and nurses, but none reported being assisted exclusively by a nurse. The number of consultations ranged from six to thirteen, with no significant difference related to the location or the professional responsible.

Based on the data analysis, thematic categories were identified that express the women's experiences and the construction of their perceptions and preparation for labor and delivery, as presented below.

Category 1 — Weaknesses in prenatal guidance.

The participants' accounts highlight significant gaps in prenatal care, especially regarding guidance on labor and delivery. Many women reported not receiving any information or considered the guidance insufficient and unclear.

> "[…] at the clinic where I worked, nobody told me anything about childbirth." (P2).
> "They said I had to be calm […]." (P4).
> "In this pregnancy, no […] I didn't get much guidance." (P9).
> "I didn't get any guidance from the doctor." (P11).
> "I sought guidance outside of the doctor because he only performed cesareans." (P14).
> "No. Neither the doctor nor the nurse told me anything." (P15).

On the other hand, some participants reported receiving guidance that they considered satisfactory, especially regarding when to seek healthcare services and the characteristics of labor:

> "Yes, I received information […] about when to go to the hospital." (P1).
> "Yes, about what the pain would be like and about the gestational weeks." (P5).
> "It was well explained." (P8).
> "The doctor did explain it to me." (P13).

Despite reports of guidance considered satisfactory, it became evident that insufficient or inconsistent prenatal information led many women to seek knowledge from other sources, forming the following category.

Category 2 — Actively seeking information and building knowledge

Given the inadequacy of the guidance received during prenatal care, several participants reported seeking information through other means, such as the internet, family, friends, and doulas, demonstrating an active movement in constructing knowledge about the birthing process.

"I only knew because I saw it on the internet." (P2).
"Most of the information came from family and friends." (P11).
"I had a doula, I read a lot, watched videos and documentaries." (P14).
"I looked for information about childbirth on the internet, out of curiosity." (P15).

This movement demonstrates that, even in the face of gaps in formal care, women mobilize different strategies to empower themselves and understand the birthing process. In this context, it is noteworthy that prior experiences, especially those related to childbirth, also influence how women perceive their preparedness, giving rise to the following category.

Category 3 — Previous experiences and perception of preparedness for childbirth

Previous experiences, especially those related to prior childbirth experience, proved relevant in women's perception of preparedness. Among first-time mothers, only one stated that she felt prepared to experience labor and delivery, having sought information from different sources. The others did not feel prepared, despite having received guidance during prenatal care or accessed other information.

Among multiparous women, prior experience influenced the perception of preparedness in a distinct way. Some reported greater confidence due to prior experiences and information received throughout their pregnancies, including support from their social network. On the other hand, two participants, even with prior childbirth experience, reported not feeling prepared, highlighting that the guidance received was insufficient in all pregnancies.

When questioned about prior experiences or having witnessed births, most reported not having had this experience, with this experience being more frequent among women with two or more pregnancies. Furthermore, it was observed that, among first-time mothers who had seven or more prenatal visits, the perception of unpreparedness persisted. One participant stated that she had not received any guidance during prenatal care, while the others considered the information insufficient. Only one did not seek other sources of knowledge.

DISCUSSION

Studies in the "*Nascer no Brasil*" Survey show that sociodemographic factors strongly influence pregnancy outcome, type of delivery, and quality of care received [12-13]. Women with higher education, higher income, in stable relationships, and who are not adolescents have better care conditions. These findings are consistent with the profile of the participants in this study, who, despite having some of these characteristics considered favorable, still reported weaknesses in prenatal care, especially with regard to preparation for labor and delivery.

In this sense, the findings of this study highlight a possible dissociation between sociodemographic characteristics considered favorable and the quality of care received. Even among women with higher education, in stable relationships, and with access to prenatal care, weaknesses related to preparation for labor and delivery persist. This result suggests that structural and organizational factors of health services, as well as the predominance of a biomedical and interventional care model, may limit the effectiveness of educational actions in prenatal care, regardless of the profile of the users. These findings reinforce the need to rethink the current model of obstetric care, which often does not guarantee women's protagonism or the provision of adequate information, even in contexts of access to health services.

Even with the advancement of public policies for obstetric and neonatal care, a significant portion of first-time mothers continue to receive superficial or insufficient guidance during prenatal care. A similar result was described in a study conducted in Fortaleza, in which most women reported not having been adequately prepared to face labor and delivery [14]. Another study also identified that, although first-time mothers value and desire vaginal delivery, feelings of fear, insecurity, and lack of emotional support persist, especially due to the scarcity of guidance from care teams [15].

Moreover, cultural, traditional, and religious practices significantly influence how women prepare for childbirth. According to researchers, healthcare teams are responsible for identifying and replacing harmful practices with evidence-based guidelines, ensuring a safer, more welcoming and positive birthing process[16].

Culture also plays a central role in constructing meanings about childbirth. Among the participants, lack of female protagonism and the still strongly established biomedical model hinder the understanding of childbirth as a physiological and safe event. Demystifying these patterns, through discussions in families, schools and community spaces, can promote change in the social imaginary, especially in relation to vaginal delivery[17].

Postpartum women who had previous cesarean sections reported feeling prepared for labor in this pregnancy, especially when they received adequate guidance and sought additional information. The exception occurred when the participant did not receive guidance during prenatal care and had not experienced labor previously, reinforcing the importance of access to qualified information.

According to the literature, women who opt for vaginal labor generally seek to break with cultural and social norms, relying on well-founded information, which increases their sense of security and protagonism[15]. Conversely, when a woman undergoes labor in a hospital setting without adequate preparation, especially after a previous cesarean section, she may feel coerced, insecure, and anxious. This generates negative experiences even when the quality of care is technically adequate[18].

In this context, although the data were collected in 2018, the findings remain relevant as they highlight subjective and structural aspects of care that tend to persist over time, especially concerning the quality of prenatal guidance and women's perception of preparedness.

Study Limitations

This study has some limitations that should be considered when interpreting the results. The first refers to the small number of participants, a characteristic inherent to qualitative research that prioritizes the depth of narratives, but which may limit the breadth of experiences identified. In addition, all interviews were conducted in a single public hospital in southern Brazil, which may restrict the generalization of the findings to other regional, cultural, or institutional contexts, especially private services or those with different care models.

Another limitation concerns the timing of data collection, which took place in the immediate postpartum period. Although this time favors descriptive richness because it is close to the experience, it can also influence responses due to fatigue, emotional relief, and neuro-hormonal changes characteristic of this period, such as the release of oxytocin, which may contribute to a more positive or less critical perception of the experience. Studies indicate that more reflective and critical elaboration on labor and delivery may emerge later in the postpartum period, suggesting that the narratives obtained in this study may reflect perceptions still under construction.

Additionally, the information obtained is based on self-reports from postpartum women, which may involve biases in memory, perception, or individual interpretation of the labor and delivery process. Reports from healthcare professionals or family members were not included, which could complement and broaden the understanding of the phenomenon investigated.

It is worth noting that, although the data were collected in 2018, a period prior to recent updates to national and international guidelines related to childbirth care, the findings remain relevant as they highlight structural and persistent aspects of care, especially regarding the quality of prenatal guidance and women's perception of preparedness. However, changes in public policies and care protocols may influence the current reality, constituting a limitation of the study.

Finally, it is important to highlight that the exclusion criteria adopted, by restricting the sample to women with physiological progression of labor and delivery, may have limited the diversity of experiences analyzed. Thus, experiences associated with complications, obstetric interventions, or more complex situations were not included, which may restrict the understanding of the phenomenon in contexts other than those investigated. Despite these limitations, the results offer relevant contributions to the understanding of the experiences and needs of women in contexts of habitual risk childbirth, especially with regard to emotional and informational empowerment during prenatal care.

Contributions for the Nursing Area, Health and Public Policy

The findings of this study highlight weaknesses in women's preparation for labor and delivery, especially regarding the guidance received during prenatal care. Even among women with sociodemographic characteristics considered favorable, gaps persist in the process of informational and emotional empowerment.

For health practice, especially in Nursing, the results reinforce the importance of improving educational actions in prenatal care, focusing on clear communication, clarifying doubts, and strengthening women's autonomy. The role of the nurse and the multidisciplinary team in providing accessible information and continuous support to pregnant women throughout their care is also highlighted. Furthermore, the findings point to the need for reflection on the care practices adopted, especially regarding the preparation of women for labor and delivery, contributing to the improvement of care strategies.

FINAL CONSIDERATIONS

The results of this study highlight weaknesses in women's preparation for labor and delivery, especially regarding the guidance received during prenatal care. It was observed that, even among participants with adequate follow-up in terms of the number of consultations, gaps persist related to the quality of information offered and preparation for experiencing this process.

It is noteworthy that prior experiences, access to information, and support networks influence women's perception of preparedness, and may contribute to greater security or insecurity in the face of labor and delivery. However, it was evident that these elements are not always sufficiently explored in the context of prenatal care. The findings also indicate that sociodemographic characteristics considered favorable do not, in themselves, guarantee adequate preparation, suggesting the need to improve care practices, especially with regard to educational actions and the welcoming of women.

Thus, this study contributes to the understanding of women's experiences and perceptions regarding their preparation for childbirth, highlighting the importance of strengthening prenatal guidance as a strategy to improve the quality of care. Future studies should broaden the analysis to different care contexts and include women with diverse childbirth experiences, in order to deepen the understanding of the factors that influence preparation for labor and delivery.

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