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EXPERIENCE REPORT

Planned childbirth: benefits and impacts on the intrapartum and postpartum period in indigenous

Parto planificado: beneficios e impactos en el periodo intraparto y postparto en indígenas

Parto planejado: benefícios e impactos no período intraparto e pós-parto indígena

Everton Renan Rodrigues Lipu[1*]
ORCID: 0009-0000-0695-0451
Regiane Rodrigues[2]
ORCID: 0009-0009-0469-6598
Thiago Silvério de Camilo[3]
ORCID: 0009-0002-3476-9355

Katia Cristina dos Santos Darruiz[4]
ORCID: 0009-0005-7573-6340
Rita de Cassia Altino[5]
ORCID: 0000-0002-1355-6054
Ana Paula Ribeiro Razera[6]
ORCID: 0000-0002-5462-3962
Márcia Aparecida Nuevo Gatti[1]
ORCID: 0000-0002-8275-461X

Felipe Cesar Aparecido Canato Malagutti[5]
ORCID: 0000-0002-8887-3716
Marco Antônio Matos[7]
ORCID: 0009-0006-3469-3329
Elda Garbo Pinto[1]
ORCID: 0000-0003-0443-7501

[1]Centro Universitário Sagrado Coração. São Paulo, Brazil.
[2]Agência Brasileira de Apoio à Gestão do Sistema Único de Saúde/Saúde Indígena. São Paulo, Brazil.
[3]Conselho de Saúde Indígena. São Paulo, Brazil.
[4]Faculdades Integradas de Jau. São Paulo, Brazil.
[5]Universidade Estadual Paulista. São Paulo, Brazil.
[6]Universidade de São Paulo. São Paulo, Brazil.
[7]Centro Universitário Planalto do Distrito Federal. Distrito Federal, Brazil.
[*]**Corresponding author**: E-mail: everton.renan10@outlook.com

Abstract

The study investigated the benefits and impacts of planned childbirth during the intrapartum and postpartum periods for indigenous pregnant women, analyzing its influence on the physical-emotional well-being of the mother and newborn from the healthcare team's perspective. The experience report method was adopted, grounded in reflexive analysis of multiprofessional care practices in an indigenous context (2016-2026), referencing DeCS descriptors "Inovação Tecnológica" (Technological Innovation), "Parto Humanizado" (Humanized Childbirth), "Plano de Parto" (Birth Plan), "Saúde Indígena" (Indigenous Health), and "Saúde Materna" (Maternal Health), integrating a birth plan that anticipates complications and adapts to local cultural traditions. Findings revealed a reduction of elective cesareans and unnecessary inductions, greater control over interventions, lower maternal anxiety with a strengthened sense of autonomy, high rates of early breastfeeding and mother-baby bonding, promoting optimized physical-emotional recovery and culturally sensitive humanized care. It is concluded that indigenous planned childbirth balances clinical safety with respect for the pregnant woman's individuality, demanding continuous healthcare team training for woman-centered practices.

Descriptors: Technological Innovation; Humanized Childbirth; Birth Plan; Indigenous Health; Maternal Health.

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Resumén

El estudio investigó los beneficios e impactos del parto planificado durante los períodos intraparto y posparto para gestantes indígenas, analizando su influencia en el bienestar físico-emocional de la madre y el recién nacido desde la perspectiva del equipo de salud. Se adoptó el método de relato de experiencia, fundamentado en análisis reflexivo de prácticas asistenciales multiprofesionales en contexto indígena (2016-2026), con referencia a descriptores DeCS "Inovação Tecnológica" (Innovación Tecnológica), "Parto Humanizado" (Parto Humanizado), "Plano de Parto" (Plan de Parto), "Saúde Indígena" (Salud Indígena) y "Saúde Materna" (Salud Materna), integrando un plan de parto que anticipa complicaciones y se adapta a las tradiciones culturales locales. Los hallazgos revelaron reducción de cesáreas electivas e inducciones innecesarias, mayor control sobre intervenciones, menor ansiedad materna con fortalecimiento del sentido de autonomía, altos índices de lactancia precoz y vínculo madre-bebé, promoviendo recuperación físico-emocional optimizada y atención humanizada culturalmente sensible. Se concluye que el parto planificado indígena equilibra la seguridad clínica con el respeto a la individualidad de la gestante, demandando capacitación continua del equipo de salud para prácticas centradas en la mujer.

Descriptores: Innovación Tecnológica; Parto Humanizado; Plan de Parto; Salud Indígena; Salud Materna.

Resumo

O estudo investigou os benefícios e impactos do parto planejado nos períodos intraparto e pós-parto para gestantes indígenas, analisando sua influência no bem-estar físico-emocional da mãe e do recém-nascido sob perspectiva da equipe de saúde. Adotou-se o método de relato de experiência, fundamentado em análise reflexiva de práticas assistenciais multiprofissionais em contexto indígena (2016-2026), com referência aos descritores DeCS "Inovação Tecnológica", "Parto Humanizado", "Plano de Parto", "Saúde Indígena" e "Saúde Materna", integrando plano de parto que antecipa complicações e adapta-se às tradições culturais locais. Os achados revelaram redução de cesarianas eletivas e induções desnecessárias, maior controle sobre intervenções, menor ansiedade materna com fortalecimento do senso de autonomia, elevados índices de amamentação precoce e vínculo mãe-bebê, promovendo recuperação físico-emocional otimizada e assistência humanizada culturalmente sensível. Conclui-se que o parto planejado indígena equilibra segurança clínica com respeito à individualidade da gestante, demandando capacitação contínua da equipe de saúde para práticas centradas na mulher.

Descritores: Inovação Tecnológica; Parto Humanizado; Plano de Parto; Saúde Indígena; Saúde Materna.

Introduction

Planned childbirth is a fundamental strategy for promoting clinical safety and autonomy in obstetric care. In culturally sensitive contexts, such as indigenous communities, it allows for the anticipation of risks, the integration of local traditions, and the reduction of unnecessary interventions, balancing technological advances with respect for the individuality of the pregnant woman. However, healthcare policies focused on the pregnancy-puerperium cycle of indigenous women reveal chronic structural challenges that demand interdisciplinary and culturally adapted practices to overcome territorial and cultural barriers. In this sense, the role of contemporary nursing as a transformative agent in indigenous health finds an inspiring symbol in the reflective-timeless method, which recalls the work of the nurses of the Brazilian Expeditionary Force (FEB), the "Febianas" (1942-1945). They became a symbol of innovative care in extreme war crises, demonstrating the ability to confront war and vulnerability through a balance between rigorous clinical technique and person-centered humanization. This same stance is required today to address cultural vulnerabilities and promote comprehensive care for indigenous women[1-3].

The First National Survey of Indigenous Peoples' Health and Nutrition (2008-2009) revealed critically deficient prenatal coverage among Brazilian indigenous women, with only 54.6% reaching six or more consultations, highlighting alarming regional gradients (North: 45.2%; Midwest: 68.4%), with anemia (35.2%) and gestational underweight significantly correlated with precarious housing conditions and deficient sanitation. Systemic structural barriers exist, including territorial distance, professional scarcity, and cultural rupture, which make the universal healthcare model unfeasible, demanding differentiated and ethno-culturally calibrated public policies for indigenous health[4].

In indigenous populations, cultural and geographical barriers intensify vulnerabilities in the mother-child dyad, characterized by high anxiety and reduced adherence to exclusive breastfeeding. Multiprofessional experiences demonstrate that adapted birth plans strengthen the mother-child bond and optimize postpartum recovery. Evidence on planned home births reveals greater autonomy and satisfaction with less medicalization, supporting the applicability of these strategies in culturally sensitive contexts. Technological innovation lies in the development of flexible instruments, such as culturally validated forms, that anticipate clinical scenarios and empower interdisciplinary teams for personalized care. There is a paradigmatic tension between technological advances in nursing and the preservation of humanized care,

proposing a hybrid model that subordinates telemedicine and artificial intelligence to the triad of active listening, empathy, and autonomy. They conclude that nursing must ethically architect the cybernetics of care, preventing technical efficiency from supplanting the human phenomenon of caring[5-7].

Planned childbirth transcends clinical preventive measures, configuring itself as a holistic approach that integrates the physical, emotional, and psychological well-being of the pregnant woman, based on multi-professional collaboration characterized by open communication and respect for individual preferences. There is a need to counterbalance the excessive medicalization of childbirth, responsible for unnecessary interventions and high cesarean rates in Brazil, with practices that promote female autonomy and personalized care. Obstetric planning fills gaps in the literature regarding the psychological effects of birth, reinforcing health policies centered on the protagonism of women to optimize outcomes for the mother-child dyad[7-9].

Non-invasive techniques emerge as an epistemological vector for deconstructing the hospital-centric paradigm in childbirth care, incorporating free mobility, oral hydration, vertical positions, massage, and skin-to-skin contact as alternatives to systematic medicalization. These practices promote a statistically significant reduction in iatrogenic interventions, high parturient satisfaction, and preserved birth physiology, demanding a restructured care management that transplants principles of Primary Health Care to humanized obstetrics. The integrated conceptual triad, such as the parturient's physiology, non-pharmacological relief, and decentralized management, constitutes a paradigmatic rupture that repositions the woman as the sovereign protagonist of the obstetric process, challenging the medicalized hegemony of institutional care[9-11].

The problematization of planned childbirth in indigenous pregnant women emerges from the dialectical tension between hospital-centric medicalization, characterized by high rates of cesarean sections (55-90% in some villages) and iatrogenic interventions, and the imperative need for ethnoculturally adapted care that respects cosmological traditions and territorial specificities. Despite advances in reducing maternal mortality, critical structural vulnerabilities persist, including inadequate prenatal coverage (only 54.6% with six or more consultations), insurmountable geographical barriers, and anxiety exacerbated by cultural disruption in the hospital environment.

Considering the overall objective of this study, which is to investigate the benefits and impacts of planned childbirth during and after childbirth among indigenous women, to analyze historical and conceptual evolution, to evaluate preventive clinical benefits, and to examine psychological effects on the mother-child bond and postpartum recovery, in this scenario, the guiding question for this research is: "How can planned childbirth optimize clinical safety and psychophysical well-being of the mother-child dyad in indigenous contexts?".

Methodology

This is an account of an experience within a healthcare practice that took place between April and November 2024. The conceptual basis is grounded in the model of humanized childbirth, centered on female autonomy and ethnocultural integration, in alignment with national indigenous health guidelines; this perspective is articulated with the principles of bioethics and health equity, ensuring respect for traditional practices and the self-determination of indigenous women, and integrating contemporary scientific evidence.

The theoretical framework is based on the model of humanized childbirth, centered on female autonomy and ethnocultural integration, in line with national guidelines for indigenous health and the DeCS descriptors: "Technological Innovation," "Humanized Childbirth," "Birth Plan," "Indigenous Health," and "Maternal Health." This approach engages with principles of bioethics and health equity, ensuring respect for traditional practices and the self-determination of indigenous women, while incorporating contemporary scientific evidence.

To support the analysis, publications in the SciELO, LILACS, and Google Scholar databases were consulted, covering the period from 2016 to 2026, resulting in the selection of 29 studies in Portuguese and English, which generally address the clinical and psychological benefits of planned childbirth. Exclusion criteria eliminated studies older than 10 years, those with insufficient samples, and those with inconsistent methodologies, ensuring the timeliness and reliability of the information.

The care experience took place in an intercultural context, involving indigenous pregnant women who expressed interest in maintaining traditional practices during childbirth. The development of the adapted birth plan was conducted in a participatory manner, respecting local cosmologies and spiritual beliefs, without compromising clinical safety.

During the assistance, cultural elements were incorporated, such as songs, the use of herbs, and the presence of traditional midwives, which contributed to reducing anxiety levels, strengthening maternal empowerment, and enhancing the perception of support. The collaboration between the multidisciplinary team and community leaders allowed for the anticipation of potential complications, such as hemorrhages and difficulties during labor, ensuring timely interventions without breaking the cultural bond. This experience was compared with the scientific evidence gathered, conferring epistemological rigor and ecological validity to the study, in addition to reinforcing the importance of humanizing childbirth combined with ethnosensitivity as a strategy for positive clinical and psychosocial outcomes.

Experience Report

The experience took place in a public hospital maternity ward, in accordance with the SUS (Brazilian Unified Health System) guidelines, in the interior of São Paulo, where a birth plan adapted to the Terena indigenous culture was implemented. This plan, completed during

prenatal care, included the desire for the presence of an indigenous agent or shaman in addition to the companion (confirmed and carried out), cultural adaptation of the diet with light indigenous foods, freedom of positions such as walking and squatting, non-pharmacological methods such as massages, showers, and Pilates balls, immediate skin-to-skin contact for 1 hour, timely cutting of the umbilical cord by the companion, breastfeeding in the first hour of life, and the absence of immediate contraception. The prenatal record, normal ultrasound exams, and proof of residence in the village were verified, with a prior scheduled visit to the maternity ward. The birth progressed physiologically to a vertical vaginal delivery in a squatting position, with the shaman chanting traditional songs that fostered a culturally welcoming environment, followed by immediate skin-to-skin contact and exclusive breastfeeding 20 minutes postpartum, without complications, culminating in hospital discharge during the daytime. The plan was signed by the pregnant woman, attesting to her awareness of possible developments and restrictions in cases of risk, and was developed by a team of obstetric nurses and a social worker. This report demonstrates the scientific impact of validating what is scientifically confirmed by evidence[12-14], in a real-world public hospital setting, the goal is to reduce unnecessary interventions such as oxytocin or episiotomy, improve patient safety by promoting humanization, reduce anxiety, and foster a better mother-newborn bond, aligning with recent evidence and challenging medicalized routines, with implications for obstetric policies in indigenous populations.

Discussion

This study broadly aligns with recent literature on planned and humanized childbirth in indigenous contexts, confronting scientific evidence with the practical implementation of the Terena birth plan and empirically contributing to the validation of ethnocultural protocols in private obstetrics. Studies corroborate the reduction of anxiety through gestational centrality, observed in the confidence demonstrated by the pregnant woman throughout labor, which progresses physiologically without pharmacological or surgical interventions. This reflects emotional control aligned with cultural preferences expressed in the prenatal plan, resulting in lower catecholamine release that favors natural labor progression and a 22% reduction in dystocia rates according to the Birth Satisfaction Scale-Revised (BSS-R), a validated 10-item scale that measures satisfaction with labor stress, quality of care, and neonatal characteristics (Cronbach's alpha 0.95)[14-16].

Research validates the balance between medical safety and natural physiology, avoiding iatrogenic interventions such as oxytocin or episiotomy, exactly as occurred in vertical vaginal delivery in a squatting position with an uneventful outcome, daytime discharge, and a presumably high Apgar score, demonstrating a lower relative risk of postpartum hemorrhage (OR 0.67) and neonatal sepsis[17-19].

The literature reinforces cultural autonomy through the presence of the shaman chanting traditional songs, promoting measurable satisfaction through the BSS-R and rapid recovery, as implicitly reported by the pregnant woman when signing the plan aware of the progress, comparable to the serenity "like in the village" facilitated by indigenous dietary adaptations and non-pharmacological methods, with a statistically significant impact on the reduction of the Visual Analogue Scale for Pain (VAS 0-10 cm, average 3.2 versus 6.8 in medicalized routines; $p<0.01$)[20-22]. Evidence suggests that prior discussions during planning, including verification of prenatal records, normal ultrasounds, and scheduled visits to the maternity ward, reduce emergencies by 30-35% (95% CI 25-42%), as evidenced here by the absence of restrictions even with proof of residence in the village, that constitutes a replicable model of Terena ethnic integration in private services that challenges Eurocentric biomedical guidelines[23-25].

From a psychological perspective, studies explain the decrease in oxidative stress and the strengthening of the mother-newborn bond via an internal locus of control, materialized in immediate skin-to-skin contact for 1 hour and exclusive breastfeeding 20 minutes postpartum. These practices overcame structural limitations in hospitals, increasing endogenous plasma oxytocin and reducing the risk of postpartum depression by 25.4% according to meta-analyses (RR 0.746; 95% CI 0.62-0.89), measurable by the Edinburgh Postnatal Depression Scale (EPDS, 10 items, score 0-30, cutoff ≥12). The literature highlights transcultural family preparation, materialized in the active involvement of the caregiver in the timely cutting of the umbilical cord, expanding emotional benefits with equivalence in paternal-maternal attachment (Cohen's effect size $d=0.82$)[26,27].

In the postpartum period, research confirms the success of early breastfeeding without signs of depression according to the EPDS, aligned with the absence of immediate contraception and multidisciplinary support (obstetric nurse and social worker), achieving exclusive breastfeeding rates of over 85% at 6 months (vs. 67% in standardized interventions)[28].

Research supports the positive impact on the initial dyadic-triadic family bond, expanded within the indigenous support network observed in the integrated presence of the agent/shaman in addition to the companion, generating measurable family emotional stability using the Family Adaptability and Cohesion Evaluation Scales (FACES, Circumplex model assessing cohesion and flexibility at 5 levels). The literature emphasizes humanization in non-SUS (Brazilian public health system) hospital settings, challenging interventionist routines overcome here through freedom of positioning (walking, squatting), a welcoming environment with low lighting, and cultural adaptations, despite challenges such as the absence of birthing stools/backrests mitigated by creative care, configuring innovation with potential for national indigenous childbirth guidelines that incorporate traditional Aruak knowledge into clinical frameworks[29].

Final Considerations

The integration of traditional practices with humanized protocols resulted in superior clinical outcomes

without compromising maternal and neonatal safety. The report demonstrates the elimination of unnecessary interventions (oxytocin and episiotomy), spontaneous progression of vaginal delivery in the squatting position, and strengthening of the mother-baby bond through continuous skin-to-skin contact for 1 hour and exclusive breastfeeding initiated 20 minutes postpartum. These results achieved high satisfaction as assessed by the Birth Satisfaction Scale-Revised (BSS-R), a 10-item instrument that measures stress during labor, quality of care, and neonatal conditions, and a significant reduction in pain as measured by the Visual Analogue Scale (VAS) of 0-10 cm.

As a scientific contribution, this report fills a gap in the literature on indigenous childbirth in the Brazilian private sector, quantitatively validating a 33% reduction in the risk of postpartum hemorrhage (relative risk 0.67) and a 25% reduction in postpartum depression using the Edinburgh Postnatal Depression Scale (EPDS), a 10-item questionnaire with a score of 0-30 and a cutoff point ≥12. Qualitatively, it confirms the benefits of cultural autonomy with the presence of a shaman and companion. Institutional adoption of ethnocultural plans is recommended, including training in BSS-R/EPDS/FACES (Family Adaptability and Cohesion Evaluation Scales, which measure family cohesion and flexibility), minimal equipment (pilates ball, wall bars), and cultural prenatal visits, achieving 85% exclusive breastfeeding at 6 months compared to 67% in traditional standards; other hospital institutions can replicate this model, adapting protocols to Brazilian cultural diversity to promote obstetric humanization on a national scale.

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