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Level of knowledge of pregnant women in the public service about humanized birth

Grau de conhecimento das gestantes do serviço público sobre parto humanizado

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ABSTRACT

Introduction: The awareness of pregnant women is fundamental to positive birth experiences. **Objective:** To analyze the level of knowledge on humanized birth of pregnant women from two public services and characterize the sample epidemiologically. **Methods:** Descriptive study using questionnaire between June and August 2017. Sample with 297 pregnant women being selected 200 after applying the exclusion criteria. Association test of variables were used (Chi-square and Fisher's exact test). **Results:** Mean age was 26.6 years. Majority were from countryside (72.5%), income up to a minimum wage (90.5%) and more of eight years of education (62.5%). 71% started prenatal care in the first trimester and it was conducted by physician in 71% of cases. 71% preferred vaginal delivery and 44% related fear of cesarean. Prenatal professional in charge did not provide information for 66.5%. 30.5% have heard about humanized childbirth, among these, 83.6% showed adequate concepts. Associations were observed between prior knowledge of humanized childbirth and origin (Aracaju) (p=0.03), higher income (p=0.02), lower abortion incidence (p=0.04), prenatal physician (p=0.04) and preference for normal childbirth (p=0.04). Among women without previous knowledge on humanized childbirth there association of correct concept with higher income (p=0.03), schooling (p=0.02) and prenatal physician (p=0.01). **Conclusion:** The majority did not know about humanized delivery, were from the countryside with lower income, preference for normal birth, were not informed on the types of delivery by the professional practitioner (in majority doctors), whom knew properly. Adequate concepts about humanized childbirth, even in the absence of prior information, were associated to socio-economic and prenatal variables.

Keywords: humanizing delivery; pregnant women; delivery, obstetric; knowledge; humanization of assistance.

RESUMO

Introdução: A conscientização das gestantes é fundamental para experiências positivas de parto. **Objetivo:** Avaliar o grau de conhecimento das gestantes em dois serviços públicos sobre parto humanizado. Caracterizar epidemiologicamente a população estudada. **Métodos:** Estudo descritivo realizado entre julho e agosto de 2017. Amostra com 297 gestantes foram selecionadas 200 após aplicação dos critérios de exclusão. Utilizados testes estatísticos de associações de variáveis (Qui-quadrado e Exato de Fisher). **Resultados:** A média de idade das gestantes foi 26,6 anos. A maioria era procedente do interior do estado (72,5%), com renda até um salário mínimo (90,5%), e com mais de oito anos de estudo (62,5%). 71% iniciaram pré-natal até o primeiro trimestre e o pré-natal foi conduzido por médico em 72% dos casos. 71% preferiam parto normal e 44% tinha medo de cesárea. Profissional pré-natalista não ofereceu informações para 66,5%. 30,5% conhecia parto humanizado, destas 83,6% apresentaram conceito adequado. Houve associação entre conhecimento sobre parto humanizado e procedência (Aracaju) (p=0,03), maior renda (p=0,02), menor ocorrência de aborto (p=0,04), médico pré-natalista (p=0,04) preferência pelo parto vaginal (p=0,04). Dentre as que não conheciam o parto humanizado houve associação de respostas corretas com a maior renda (p=0,03) e anos estudados (p=0,02) e médico pré-natalista (p=0,01). **Conclusão:** A maioria desconhecia o parto humanizado, era procedente do interior com menor renda, preferência por parto normal, sem informações quanto aos tipos de parto pelo profissional executante (na maioria médicos), quem conhecia adequadamente. Conceitos adequados sobre parto humanizado mesmo na ausência de informação prévia associaram-se às variáveis sócioeconômico e pré-natal.

Palavras-chave: parto humanizado; gestantes; parto obstétrico; conhecimento; humanização da assistência.

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INTRODUCTION

Social movements, such as the feminist social movement, were of great importance, as they contributed not only to criticizing the women's health care system, as well as in the awareness of pregnant women, partners and health professionals, being of fundamental importance to the understanding of care in childbirth[1]. By the 21st century, home birth was being replaced by institutionalized birth and the continued assistance to women was becoming increasingly restricted. What ended up contributing to the dehumanization of childbirth care and consequently the lived experiences[2].

The search for changes in the routine of childbirth care and all that it represents for pregnant women is justified by the adoption of techniques and means that are above the pregnant woman herself, making her submissive to the defined behaviors and turning them into mere extras in the birth scenario[3].

The quality of care and experiences of parturients during labor and birth influence maternal and neonatal outcomes[4].

In Brazil, the Ministry of Health created the Program for the Humanization of Prenatal Care and Childbirth on January 6, 2000. The program encompasses assistance during pregnancy, childbirth and the postpartum period, with the aim of becoming a guarantee of civil rights of women during the maternity period[5].

The progress of medicine has led to cesarean delivery, safer techniques that enable a proper procedure for women with medical reasons, even though the morbidity of the surgical procedure has not been completely annulled, which exposes mothers and children to great risks[6-8].

In the study by Pinheiro *et al.*[9], it was highlighted that normal childbirth can be experienced in two ways, as a pleasurable experience, of satisfaction, or as something traumatic, becoming something that they would never want to happen again. Better care delivery becomes a vital life-saving intervention[10].

Humanized childbirth is an alternative to the technocratic model that was instituted a few decades ago. For some scholars, humanized childbirth is described as respect for a woman's values, culture, belief, and dignity, as well as the desire for control over childbirth where the contribution of birth and related decisions are perceived[11].

This study aimed to evaluate the level of knowledge of pregnant women attended in the public service regarding humanized birth and to verify associations with socioeconomic and prenatal factors.

METHODS

Descriptive, prospective, observational, cross-sectional study. It was held at the Ambulatório de Pré-natal do Hospital Universitário da Universidade Federal de Sergipe (UFS/Prenatal Clinic of the University Hospital of the Federal University of Sergipe), Brazil, and the Centro de Atenção Integral a Saúde da Mulher (Center for Integral Attention to Women's Health) of Sergipe, Brazil, from July to August 2017. Data were collected through a previously prepared questionnaire, which was composed of open and binary yes or no variables. The questionnaire had 34 questions that addressed characteristics about social data, comorbidities, prenatal care, pregnancy and childbirth. In this collection instrument, the authors addressed the knowledge of humanized childbirth and whether this prior knowledge was adequate or not. The study included all pregnant women who attended the prenatal outpatient clinic of the University Hospital of UFS during the study period who agreed to participate in the interview after signing the Informed Consent Form and who had attended more than one prenatal consultation.

For the sample calculation, considering a percentage of normal deliveries in Brazil in 2015 of 44.4%, and a total of 4.744 vaginal deliveries performed in the city of Aracaju, Sergipe, Brazil, in the same year, the Statcalc program was used. of the public domain software Epi-Info 7, with a 90% confidence interval and a 5% margin of error, considering the 10% increase for eventual losses, the sample size was calculated in 297 pregnant women[12].

Exclusion criteria were the first-born mothers who were in the first prenatal visit, as well as inadequately answered questionnaires.

In the study, we captured 304 pregnant women, out of which 104 were excluded from the study because they did not answer the questionnaire adequately with blank or initeligible answers or because they were primiparous in the first prenatal consultation, therefore unable to assess prenatal care adequately. 200 pregnant women followed all inclusion criteria.

For statistical analysis, frequency distribution tables were made from the variables and data collected. Numerical variables were expressed as mean and standard deviation as they met the normality assumption. This assumption was tested using the Shapiro-Wilk technique. Categorical variables were summarized by simple frequency and percentage. To assess the association between categorical variables, Pearson's chi-square test or Fisher's exact test were used, when appropriate. To compare the mean age between two groups, Student's t-test for independent data was used. It was considered as significance level $p=0.05$ and Power $\beta=0.80$. Statistical Package for Social Sciences (SPSS) 21 was used.

Data collection was only initiated after submission and approval of the project by the Ethics and Research Committee of the Federal University of Sergipe under number CAAE 68608017.9.0000.5546 on July 10, 2017.

RESULTS

General characterization of the sample

A total of 200 interviews were conducted through a questionnaire from July to August 2017. The pregnant women had an

average age of 26.6 years, with a minimum of 11 years and a maximum of 47 years. Some pregnant women declared themselves brown 134 (67%). Most of the pregnant women interviewed 145 (72.5%) came from the countryside, followed by 51 (25.5%) from Aracaju. They presented monthly income of half to a minimum wage 96 (48%). Schooling contemplating only elementary school was found in (76) 38%. 84 (42%) pregnant women and 116 (58%) with parity greater than one were classified as primiparous women (Table 1).

Prenatal characterization in the sample

The start of prenatal care occurred before completing the first trimester in 142 (71%) pregnant women. The doctor in most cases conducted prenatal care, 144 (72%). Of the 200 participants, 142 (71%) reported preference for normal delivery. The fear of cesarean section was expressed by 88 (44%). Most of the time (66.5%) there was no information about the types of delivery by the predelivery professional (Table 1).

Knowledge about normal and humanized delivery of the sample

Reported fear of normal birth pain 116 (58%) pregnant women. Most 187 (93.5%) reported knowing other women who had children by normal birth. The search for information on the types of delivery was absent in 118 (59%). Regarding humanized delivery, they had prior knowledge ("heard" about) 61 (30.5%) pregnant women. Of these, 51 (25.5%) presented an adequate answer regarding the concept. Of the 139 pregnant women who had never heard of humanized childbirth, 91 (65.5%) did not respond adequately to the question of what they understood about "humanized childbirth" (Table 2).

Association of sociodemographic characteristics with knowledge about humanized birth of the sample

We associated the variables (referred color, origin, income, education, pregnancies, parity, abortions and prenatal characteristics) with the knowledge of humanized birth. The fact of having a previous knowledge about humanized birth was associated with origin (living in Aracaju) with p=0.03, having higher income (p=0.02), lower occurrence of abortion (p=0.04), having physician as a prenatal professional (p=0.04) and preference for vaginal delivery (p=0.04) (Table 3).

Among women who reported having a previous knowledge of humanized childbirth, what they knew was asked, and there was a high frequency (83.6%) of adequacy of response to the theme (Table 2). Comparison of sociodemographic and prenatal characteristics with these two groups (adequate and inadequate response) showed no significant difference. However, there was a higher frequency of Aracaju residents and higher income in the adequate response group, and a higher average age in women with inadequate response (Table 4).

Considering the pregnant women who denied having previous knowledge about "humanized childbirth" and were later asked with a second question, a high frequency (34.5%) of adequate response was observed regarding the concept that they attributed to the expression "humanized childbirth". The adequate response for this group of women was associated with higher income (p=0.03) and years studied (p=0.02) and having the doctor

Table 1: Sociodemographic and prenatal characteristics of pregnant women (N=200).

Variables	N (%) or average±standard deviation
Age (years)	26.64±7.93
Provenance, n (%)	
Aracaju	51 (25.5)
Countryside	145 (72.5)
Other states	4 (2.0)
Income, n (%)	
< 1/2 minimum wage	85 (42.5)
1/2 to 1 minimum wage	96 (48.0)
2 to 5 minimum wages	18 (9.0)
10 to 13 minimum wages	1 (0.5)
Schooling, n (%)	
≤ 8 years of study	76 (38.0)
> 8 years of study	123 (61.5)
No response	1 (0.5)
Number of pregnancies, n (%)	
≤ 1	84 (42.0)
> 1	116 (58.0)
Number of births, n (%)	
≤ 1	89 (44.5)
>1	111 (55.5)
Abortion, n (%)	
No	159 (79.5)
Yes	41 (20.5)
Beginning of prenatal, n (%)	
Before the 1st trimester	142 (71.0)
After the 1st trimester	54 (27.0)
Apsent	4 (2.0)
Prenatal professional, n (%)	
Physician	144 (72.0)
Physician or nurse	56 (28.0)
Prenatalist reported on types of delivery	
No	127 (63.5)
Yes	67 (33.5)
Apsent	6 (3.0)
Preference of childbirth, n (%)	
Normal	142 (71.0)
Cesarean section	56 (28.0)
No preference	2 (1.0)
Cesarean section fear, n (%)	
No	112 (56.0)
Yes	88 (44.0)
Fear of pain, n (%)	
No	84 (42.0)
Yes	116 (58.0)

as prenatal care (p=0.01). The group that presented an adequate answer answered that the information about the type of delivery was not from the prenatal professional in 38 (27.3%) (Table 5).

DISCUSSION

In the Ministry of Health Technical Manual on prenatal care, it is stated that the first prenatal consultation should be held in the first trimester of pregnancy, with the aim of providing effective prenatal care, if interventions are needed, be performed in skilled time[13]. In our survey most women had their first prenatal visit before the end of the first trimester of pregnancy showing that there is concern about an appropriate prenatal.

During prenatal consultations it is necessary to establish educational practices as a way to prepare women for motherhood. Such measures influence the choice of the type of delivery by the pregnant woman. Thus, the health professional needs to be careful in observing the possible doubts and lack of information that pregnant women present. Consequently, the sharing of knowledge of the professional will promote value and self-esteem for patients, generating confidence, security[14], etc. It was observed that the prevailing performing professional in prenatal care was the physician, and that in most of the general follow-up, information about the types of delivery was not provided. This lack of information raises questions about the prenatal care, whether there is a lack of knowledge about humanized childbirth or whether there is negligence in the physician's omission of subsidies on the subject.

The search for information on the forms of delivery was also evaluated, and, according to the data obtained, pregnant women sought information on the types of births in 41% of cases, against 55% of those who did not. These findings are in agreement with the ambiguous behavior of pregnant women reported by the study by Silva *et al.*[15], and contrast with Sodré *et al.*[16], who found that when there is a need for complementation of the elements provided, the pregnant woman seeks to answer your questions, either on the internet and/or with acquaintances, thus revealing important means of providing information for later decision making[15,16].

Failure in the process of information about childbirth by the professional prenatal performing, part of women (63.5%) reported not having received any information regarding the types

Table 2: Knowledge about normal and humanized childbirth in pregnant women attended in public service (N=200).

Variables	N (%)
Know women who had a normal birth	
No	13 (6.5)
Yes	187 (93.5)
Fear of pain	
No	84 (42.0)
Yes	116 (58.0)
Have searched for information on delivery types	
No	110 (55.0)
Yes	82 (41.0)
Apsent	8 (4.0)
Have heard about humanized childbirth	
No	139 (69.5)
Yes	61 (30.5)
If so, the meaning of humanized childbirth	
Adequate answer	**51 (25.5)**
Inadequate answer	10 (5.0)
Apsent	139 (69.5)
If not, what does the expression "humanized childbirth" tells	
Adequate answer	48 (24.0)
Inadequate answer	91 (45.5)
Apsent	61 (30.5)

Table 3: Sociodemographic characteristics of pregnant women and prenatal care due to previous or non knowledge about humanized birth.

Variables	Have heard Yes (N=61)	Have heard No (N=139)	p*
Age (years), average±standard deviation	26.31 ±7.93	26.78 ± 7.89	0.70
Provenance, n (%)			
Aracaju	23 (**37.7**)	28 (20.1)	**0.03***
Countryside	37 (60.7)	108 (**77.7**)	
Other states	1 (1.6)	3 (2.2)	
Income, n (%)			
<1/2 minimum wage	22 (36.1)	63 (**45.3**)	**0.02***
1/2 to 1 minimum wage	28 (45.9)	68 (**48.9**)	
2 to 5 minimum wages	11 (**18.0**)	8 (5.8)	
Schooling, n (%)			
≤8 studied years	17 (28.3)	59 (**42.4**)	**0.04***
>8 studied years	43 (**71.7**)	80 (57.6)	
Number of pregnancies, n (%)			
≤1	26 (42.6)	58 (41.7)	0.90
>1	35 (57.4)	81 (58.3)	
Number of births, n (%)			
≤1	30 (49.2)	59 (42.4)	0.37
>1	31 (50.8)	80 (57.6)	
Abortion, n (%)			
No	54 (**88.5**)	105 (75.5)	**0.03***
Yes	7 (11.5)	34 (24.5)	
Beginning of prenatal, n (%)			
In the 1st trimester	43 (71.7)	99 (72.8)	0.87
After the 1st trimester	17 (28.3)	37 (27.2)	
Prenatal professional, n (%)			
Physician	50 (**82.0**)	94 (67.6)	**0.04***
Physician or nurse	11 (18.0)	45 (32.4)	
Birth preference, n (%)			
Normal	50 (**82.0**)	92 (66.2)	**0.02***
Cesarean section	11 (18.0)	45 (32.4)	
Prenatalist reported on types of delivery			
No	35 (58.3)	92 (68.7)	0.16
Yes	25 (41.7)	42 (31.3)	
Know women who had a normal birth, n (%)			
No	2 (3.3)	11 (7.9)	0.22
Yes	59 (96.7)	128 (92.1)	

*Chi-square test

of delivery. Most (58%) of the pregnant women interviewed said they were afraid of the pain experienced by a normal birth. The desire for a caesarean section is strengthened by fear and misinformation[17-19]. In agreement with this statement, the literature shows that the fear of labor pain depends on how the pregnant women were conducted during prenatal care[20]. The lack of care and attention to maternal fears during prenatal care, as well as misinformation about pain, makes women unfit to make the best decision. There is a need for health professionals to enable women to cope with the birth process, so that it can provide the opportunity to regain control and decision power, avoiding the use of unnecessary interventions. The cesarean culture that prevails in our country means that the prenatal assistant doctor does not value the incentive to the patient who wants the normal delivery and tries to guide and reassure her about the event. It is noticeable that the recommendations of the Ministry of Health to provide the presence of a family member during childbirth, as well as to provide information about the event itself, are not practiced by the health professional[21].

The predominance of choice is still natural delivery, reported by 71% of pregnant women, as occurred in the study by Nascimento *et al.*, Where most participants also expressed

Table 4: Sociodemographic characteristics of pregnant women and prenatal care due to the adequacy of the response of pregnant women who reported having previous knowledge of humanized birth.

Variables	Adequate answer (N=51)	Inadequate answer (N=10)	p*
Age (years), average±standard deviation	25.55 ± 8.19	**30.22** ± 6.356	0.09
Provenance, n (%)			
Aracaju	20 (**39.2**)	3 (30.0)	0.07
Countryside	31 (60.8)	6 (60.0)	
Other states	0 (0)	1 (10)	
Income, n (%)			
<1/2 minimum wage	17 (33.3)	5 (50.0)	0.51
1/2 to 1 minimum wage	25 (49.0)	3 (30.0)	
2 to 5 minimum wages	9 (17.6)	2 (20.0)	
Schooling, n (%)			
≤8 studied years	16 (31.4)	1 (11.1)	0.21
>8 studied years	35 (68.6)	8 (88.9)	
Number of pregnancies, n (%)			
≤1	22 (43.1)	4 (40.0)	0.85
>1	29 (56.9)	6 (60.0)	
Number of births, n (%)			
≤1	25 (49.0)	5 (50.0)	0.95
>1	26 (51.0)	5 (50.0)	
Abortion, n (%)			
No	46 (90.2)	8 (80.0)	0.35
Yes	5 (9.8)	2 (20.0)	
Beginning of prenatal, n (%)			
In the 1st trimester	37 (72.5)	6 (66.7)	0.72
After the 1st trimester	14 (27.5)	3 (33.3)	
Prenatal professional, n (%)			
Physician	43 (84.3)	7 (70.0)	0.29
Physician or nurse	8 (15.7)	3 (30.0)	
Preference of birth, n (%)			
Normal	43 (84.3)	7 (70.0)	0.28
Cesarean section	8 (15.7)	3 (30.0)	
Prenatalist reported on types of delivery			
No	31 (62.0)	4 (40.0)	0.19
Yes	19 (38.0)	6 (60.0)	
Know women who had a normal birth, n (%)			
No	1 (2.0)	1 (10.0)	0.19
Yes	50 (98.0)	9 (90.0)	

*Chi-square test

Table 5: Sociodemographic characteristics of pregnant women and prenatal care due to the adequacy of the response of pregnant women who did not claim previous knowledge of humanized delivery.

Variables	Adequate answer(N=51)	Inadequate answer (N=10)	p*
Age (years), average±standard deviation	26.63 ±8.297	26.86 ±7.714	0.87
Provedance, n (%)			
Aracaju	11 (22.9)	17 (18.7)	0.84
Countryside	36 (75.0)	72 (79.1)	
Other states	1 (2.1)	2 (2.2)	
Income, n (%)			
<1/2 minimum wage	21 (43.8)	42 (**46.2**)	**0.03***
1/2 to 1 minimum wage	21 (43.8)	47 (**51.6**)	
2 to 5 minimum wages	6 (**12.5**)	2 (2.2)	
Schooling, n (%)			
≤8 studied years	14 (29.2)	45 (**49.5**)	**0.02***
>8 studied years	34 (**70.8**)	46 (50.5)	
Number of pregnancies, n (%)			
≤1	18 (37.5)	40 (44.0)	0.46
>1	30 (62.5)	51 (56.0)	
Number of births, n (%)			
≤ 1	18 (37.5)	41 (45.1)	0.39
>1	30 (62.5)	50 (54.9)	
Abortion, n (%)			
No	34 (70.8)	71 (78.0)	0.35
Yes	14 (29.2)	20 (22)	
Beginning of prenatal, n (%)			
In the 1st trimester	35 (72.9)	64 (72.7)	0.98
After the 1st trimester	13 (27.1)	24 (27.3)	
Prenatal professional, n (%)			
Physician	40 (**83.3**)	54 (59.3)	**0.01***
Physician or nurse	8 (16.6)	37 (40.7)	
Birth preference, n (%)			
Normal	29 (60.4)	63 (69.2)	0.56
Cesaren section	18 (37.5)	27 (29.7)	
No preference	1 (2.1)	1 (1.1)	
Prenatalist reported on types of delivery			
No	38 (**79.2**)	54 (62.8)	**0.05***
Yes	10 (20.8)	32 (37.2)	
Know women who had a normal birth, n (%)			
No	5 (10.4)	6 (6.6)	0.43
Yes	43 (89.6)	85 (93.4)	

*Chi-square test

preference for the practice of normal birth, with the same justifications that we found[18]. This fact contradicts the technocratic model of care, which understands childbirth as a pathological, hospital-centered and medicalized event, without meeting criteria, as it has become routine in Brazil. Therefore, there is a permanence in the increase of cesarean section rates, as can be observed by DATASUS in 2015, in which about 55.5% of the deliveries performed in Brazil were cesarean section[1,12,16,18]. Beckett, in his study, questioned whether pregnant women who choose cesarean section would be aware of the effects that such a procedure could result, noticing a tendency of these patients to make choices based on limited knowledge[22]. It is also worth noting that 44% of the pregnant women interviewed also reported being afraid of cesarean delivery, and 60.5% that the fear of the pain of normal delivery would not make them choose the cesarean section. Perhaps a better reception of prenatal staff with emphasis on lectures, inclusion of family members and improved quality of consultations would increase the knowledge of the pregnant woman and allow her to experience childbirth with less fear.

Part of the pregnant women knew other women who had children by normal birth who offered them information about their experiences. According to the study by Nascimento *et al.*[18], the experiences reported by other puerperal women are also taken into account in the preference for the mode of delivery.

Factors such as the duration of labor, the intensity of pain, the relationship established with the professionals, the presence of a family companion and the emotional support, contribute to the high satisfaction of the parturient care, which implicitly shows a preference for the humanized childbirth, because it is noticeable that the execution of the practices of this type of childbirth turns birth into a unique and indescribable moment[23-26].

When asked if they had heard or had any knowledge about "humanized childbirth" only 30.5% of pregnant women said yes. This fact can be observed in situations where women are unaware of normal childbirth, as a result of non-adherence by health professionals to the process of humanization of childbirth, even though something recommended by the Ministry of Health[21]. According to Beauchamp & Childress[27], the understanding of pregnant women about childbirth itself depends mainly on the provision of information regarding the rights they have and that must be preserved, so that the real sense of respect and satisfaction can remain.

Among the 139 pregnant women who stated that they had never heard about humanized childbirth, 24% answered adequately about what the expression (humanized childbirth) conveyed. That is, although they have never explicitly heard about humanized childbirth, some were able to conceptualize satisfactorily, proving that at some point they were exposed to the characteristics that involve this process.

From the associations we made with sociodemographic and prenatal characteristics with previous knowledge about humanized or not childbirth (Table 3), there was a level of significance with the origin of the pregnant woman, higher income, occurrence of abortion, the prenatal professional and preference for vaginal delivery. These findings lead us to infer that women from higher income urban centers seek more information about their pregnancy and forms of delivery. Social inequalities affect the culture of care and attention given to health in an individualized way[28]. We understand that residence in capitals, as well as having higher income, influences knowledge about humanized childbirth, as this allows the insertion of pregnant women in a different environment, with cultures and ways of living, where there is greater availability of means for seeking information[13]. The association with the previous occurrence of abortion could be a factor that makes the pregnant woman more careful regarding the data related to pregnancy and childbirth.

Appropriate knowledge of humanized childbirth may have translated into a greater preference for normal childbirth. According to Nascimento *et al.*[18], the choice of delivery type is influenced by previous experiences and the degree of interaction of the prenatal professional.

Of the pregnant women who reported having a previous knowledge of humanized birth, 84% (51) were able to formulate an adequate answer about the concept. Comparing the group of those who had prior knowledge with the variables (Table 4), no significant association was found. There was a high frequency of adequacy of response with the concept in pregnant women living in Aracaju and with higher income, as found in the previous association, and a higher average age in the group of inadequate responses.

Taking into account the group in which there was denial about prior knowledge of humanized childbirth, and then asked a second question to assess what they understood from the expression (humanized childbirth), a considerable frequency of appropriate responses was observed (24%, compared to 45.5% inadequate responses). After association with the variables, there was statistical significance in relation to income and education of pregnant women. The pregnant women who presented adequate answers were those who had higher monthly income and higher level of education. In agreement with the research by Lequizamon *et al.*[29], the increased preference for natural childbirth occurred in pregnant women with higher education (complete high school and higher education), and therefore, a better adequacy of responses in pregnant women with more of eight years of schooling.

There was a significant association between the group of women who did not know humanized childbirth and the information variable provided by the prenatalist or not. However, the adequate response subgroup is more frequent in those who did not receive information from the prenatal care professional. We could justify

this occurrence as an alternative way that some pregnant women found to inform themselves, because the knowledge that should have been transmitted prenatally did not occur.

Implementation measures for humanized childbirth in institutions and training of professionals to disseminate information during prenatal care are measures that should be taken to ensure that women decide on their way of giving birth without being linked to myths, beliefs or will of others.

It was concluded that most women were unaware of humanized childbirth, coming from the countryside with lower income, preference for normal childbirth, without information on the types of delivery by the performing professional in most physicians, who knew responded appropriately. Prior knowledge about humanized childbirth and adequate response, although in the absence of previous information, socioeconomic and prenatal variables were associated.

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