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Humanized childbirth, a link to humanitarian treatment, synonymous with quality obstetric care at the 1st level of care in Mexico

Summary

Bringing a new being into the world is a relevant and transcendent event in a woman's life, which will be marked for the rest of her life. However, it can be experienced as a painful and traumatic experience.

Objective: Analyze the most effective actions to improve the quality of humanized delivery care in low-risk pregnant women in hospitals of 1st and 2nd level of care.

Methodology: A narrative review was carried out that includes a critical, reflective analysis of humanized childbirth. The review of: original articles, revision of doctoral and master's theses was carried out. The adopted search strategy included keywords or descriptors, connected by means of the boolean operator and. The keywords used were "humanization", "delivery", "human needs", and breastfeeding, these being identified through Medical Subject Headings 2020 Serach MeSH, in this way the referred articles, descriptors in language were used for the search. Spanish and English. The search was carried out in various databases. Information collection time 6 months, (August 2022 to February 2023).

Results: The review allowed us to analyze in a standardized way the historical evolution of humanized childbirth and the transcultural significance that it represents and to a large extent to be carried out, and how it will reinforce the multidisciplinary health team that cares for women in this process, to offer different strategies. to be this stage an unforgettable and humanistic experience that you will never forget.

Conclusions: Humanized childbirth is translated into a birth with a humanistic character which includes: the prenatal stage, labor, delivery and the puerperium, where the protagonists are the pregnant woman and the newborn, receiving dignified, free treatment. of violence and based on human and ethical rights.

Keywords: humanization, childbirth, human needs, breastfeeding

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Introduction

In Mexico, the history of care that is carried out during the prenatal stage, childbirth, and the puerperium begins in pre-Hispanic times, when this physiological process was classified as a merely divine and majestic entity.[1]

History of obstetric practice. In the New Spanish period, the exercise of birth was available to female midwives, in the Viceroyalty period the male figure was eliminated from the context, since the task of labor was directed by female midwives and it is in that moment when the position of the seated woman to give birth became relevant. In the 19th century, the lithotomy or gynecological position was adopted, which is practiced to this day in hospital care centers and maternity wards.

In the year 1774, "the Department of Reserved Births was created at the "Hospital de los Pobres" in Mexico City, in charge of the Clergy with the objectivity of keeping the identification of the parturient anonymous, avoiding infanticide in the event that the pregnancy was caused by adultery."[2] In Mexico, after decades of work and scientific arguments, in the 1990s it was possible to institutionalize the technique and benefits of breastfeeding in public institutions, creating breastfeeding committees and institutions where a risk and humanistic approach was taken. the care of pregnant women in the prenatal stage, childbirth and the puerperium, with the guidelines for a respected and humanitarian childbirth, implemented in the Maternal and Child Group Research Center at Birth, under the direction of Dr. Carlos Vargas García, who brought with it the decrease in maternal-fetal morbidity and mortality, thus innovating the humanitarian model directed by the WHO in friendly childbirth and which is currently carried out in different units and maternity hospitals in Mexico.[1]

Concept of labor (WHO)

The World Health Organization (WHO) defines childbirth as the beginning of a labor process and uterine dynamics, beginning with cervical changes, with cervical dilation and effacement until the birth of the RN (newborn) with the expulsion of the annexes, which occurs spontaneously and physiologically in the cephalic position, with an interval between 37 to 41 weeks of gestation (for full-term deliveries), with expulsion of the placenta and clear amniotic fluid with white lumps, sustainability being that a delivery without complications, low risk and free of neonatal hypoxia is being evaluated.[2]

WHO recommendations for humanized childbirth

Emphasis is placed on: allowing the woman to make a decision about her self-care, continuous accompaniment through the strengthening of support networks, through freedom of movement and position during labor in labor, (outpatient TDP) no using invasive methods (enema, trichotomy, episiotomy, amniotomy at the beginning of PDT, indiscriminate use of exogenous oxytocin, obstetric anesthesia if not required, intravenous cannulation, among others).[3,4]

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Treviza M Melo[4] considered the nursing professional as a member of a multidisciplinary team, as the main actor in managing delivery care with a merely humanistic vision and process.[5] The importance of childbirth and birth is based on the Bioethical principle of Autonomy, increasing the control that women have over the childbirth process, contributing to having an assertive effect on the process and its stability as a dynamic and progressive event.

Concept of humanized childbirth

It is called humanized or respected childbirth, to the childbirth process in which the will of the woman who is going to give birth is respected according to the physiological times in this stage, developed in a way that is as natural and physiologically possible and free of all violence (Figure 1).[6] According to Lidy[6] humanized childbirth: "It encompasses different needs and preferences of the parturient, such as: respected childbirth, by recovering a leading role for the pregnant woman at the time of birth, recovering their subjectivity and freedom of themselves for the best shot decision-making at this stage and the delivery process, synonymous with psycho-prophylactic delivery, based on training prior to birth, to educate the pregnant woman physically and psychologically."[7] The educational processes involve addressing the anatomical and physiological changes that occur each trimester in a physiological and gradual manner, also through exercises to strengthen the pelvic and perineal muscles, relaxation and concentration exercises, breathing exercises to avoid periods of hypoxemia, music therapy combined with aromatherapy, all combining a link of positive sensations and emotions, making the TDP (labor) process more bearable, to reduce anxiety and pain.

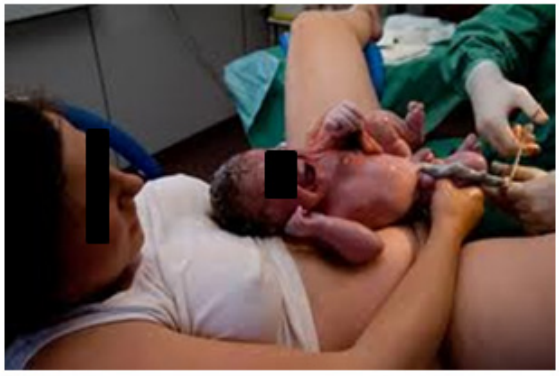

Figure 1 Natural Childbirth.[29]

Grantly Dick-Read released the term natural childbirth, to raise awareness to be able to carry it out without intervention. At this same time, the Soviet Union, Nicolaiev and Platonov applied similar techniques to Pavolov's conditioning model, through the culture of pain during childbirth and living it as something merely traumatic, so later this model was refuted through the slogan of "cleaning the mind" with a reconditioning so that later it was called psychoprophylactic delivery.

At the beginning of the 40's it is described that fear interferes in the TDP, by increasing pain and anxiety. Based on these elements, the French doctor Fernand Lamaze perfected the psychoprophylactic method, as a help mechanism during the labor process, considering the importance of elements such as: breathing exercises, relaxation techniques, favoring oxygenation and lowering the threshold to pain. The Lamaze method became relevant after the publication of the book "Thank you", in the USA by Marjorie Karmel. Later, in 1960, the American Society for Psychoprophylaxis in Obstetrics (ASPO) was created together with the International Association of Childbirth Educators (ICEA).[8]

Birth is considered as a unique and unrepeatable event and as a natural process, with intercultural significance, are essential for quality obstetric care, as well as other physiological processes integrated into the mother-child bond, such as immediate breastfeeding, together with the maternal attachment and co-sleeping, which refers to the practice of sleeping together in the same room, mother and child, reducing the risk of cot death in the newborn.[1] In 1956, breastfeeding boomed with the foundation of the International Milk League by a group of women in the city of Illinois, USA, taking charge of giving advice to women who, due to lack of information, or social pressure they had trouble breastfeeding their children. For this reason, groups were created in Mexico in 1964 to support problems related to breastfeeding; nowadays it has spread to more than 65 countries, serving more than 300,000 women with doubts or problems with breastfeeding, forming thus, support networks for breastfeeding with emphasis on new women with no experience in the subject (Figure 2).

Figure 2 Mother and postpartum newborn.[30]

The WHO and UNICEF recommend the 10 steps of successful and exclusive breastfeeding up to 6 months and complementary up to two years, with its three annexes in reference to the international code of non-commercialization of breast milk substitutes, friendly treatment (humanized childbirth) and breastfeeding and HIV. Breastfeeding promotes sensory and cognitive development, protecting the baby from infectious diseases, reducing mortality from sudden crib death and allergy diseases Figure 3.

Figure 3 Home delivery.[31]

While in Latin America, three other organizations that promoted humanized childbirth joined, such as: The Network for the

Humanization of Childbirth and Birth (ReHuNa), The Coalition to Improve Maternity Services (CIMS) and the Latin American and Caribbean Network for the humanization of labor and birth (Relacahupan).

In Mexico, NOM 007 SSA2-(1993), recognizes interculturality, vertical birth, humanization of pregnancy and childbirth, where the legal obligations of health care providers related to the quality of care and scientific evidence is established.

In addition to the normative bases for humanized childbirth are: the political constitution of the United Mexican States, the general health law, the Official Mexican Standard NOM 007 SSA2-1993, National Policy on Health and Sexual and Reproductive Rights (approved on April 2005 by Executive Decree No. 2717) The National Development Program 2013-2018, the Clinical Practice Guidelines, The National Program for Equal Opportunities and Non-Discrimination against Women 2013-2018, The Health Sector Program 2014- 2018 and the Legal Framework that supports Traditional Medicine and Midwifery.[9] Humanized delivery care was widespread in European countries in the 1990s, by 1993 in England 78% of hospitals implemented a new delivery care in wards and by 2007 it was implemented as a strategy in Spain, Normal Delivery Care in the National Health System (Ministry of Health and Consumption).[10] Humanized Childbirth is characterized by respect for the rights of parents, boys and girls at the time of birth in accordance with the needs and desires of the family.[11]

Mexico managed to reduce its maternal mortality ratio (MMR) by 57.8% in 2015, in accordance with the millennium goals.[12] At the first level of care, 93% of the heads of medical and nursing staff, as well as midwives, determine a high degree of compliance with the goals of evidence-based practices, this drop to 45% at the second level of care.[13]

Midwifery in Mexico

Midwifery as a profession in Mexico dates back to the last century, they are scientifically informed professionals who know all the strengths and weaknesses of the population they attend, with the necessary support and prepared to be critical, organized, assistance, with an emphasis on accompaniment, giving union strength in which the parturient places her trust to achieve the goal of giving birth to a healthy newborn without complications.[14]

In the 80's, the praxis of childbirth care began to be questioned about what should be quality care, both by the parturients themselves and by qualified health personnel. Due to this change in ideology, some states and international organizations initiated legislative modifications in this section. Thus, in 1985 (Brazil), the Regional Office for Europe of the World Health Organization (WHO), the Pan American Health Organization, and the Regional Office for the Americas held a conference on appropriate technology for humanized childbirth, with the participation of: a multidisciplinary team made up of: midwives, nurses, nurses, obstetricians, pediatricians, gynecologists, epidemiologists, sociologists, psychologists, economists, health administrators and people who already had a history of having had a birth by childbirth, among others.[15] The WHO determined that the medicalization that was carried out in childbirth care did not respect the right of women to receive dignified care, not counting and not adding their needs, expectations and limiting their autonomy.

WHO recommendations for humanized childbirth

The WHO promulgated some recommendations to avoid unjustified practices that were carried out in delivery care in a systematic and routine manner. Emphasizing the woman "as a person, assuming that she has the right to adequate care in humanized childbirth, focused on herself, through her active participation in the planning, execution and evaluation of her care, giving her comprehensive, holistic quality care" and warmth. While the WHO, the Ministry of Health and Consumption and those responsible for Health in the different autonomous communities began to promote lines for less interventionist delivery care in low-risk pregnancies and deliveries.[16]

The WHO (2015) sets out criteria for the care of a humanized delivery provided by the health team that attends a low-risk delivery using the following criteria.

a. Identify the cultural characteristics in pregnancy and childbirth care, respecting the traditions of women and thus satisfying their individual needs and requirements for quality care and warmth, with humanitarian and individualistic treatment.

b. Facilitate physical, emotional and psychological support to the patient, her partner and her family, during labor and postpartum to reduce stress and anxiety in the face of a new and unknown event.

c. To be treated with confidentiality, the patient has the right to have all the information expressed by her public servant (Obstetrician, Perinatal Nurse, Midwife or other competent professional in the area) be handled with confidentiality and respect for her autonomy.

d. Informed consent is part of the clinical file in which it is provided upon admission of the parturient, making her aware of the possible risks she may be involved at a certain time according to her obstetric risk. In the case of requesting obstetric analgesia, you must fill out another analgesic consent form, which will be provided by the anesthesiologist, informing the anesthetic and surgical risk that this implies in the event of an emergency event of a surgical nature.

e. The accompaniment, during labor, is carried out in some 1st and 2nd level centers by the patient's partner or by another person, if she does not have a partner. In the case of being a single mother, the parturient decides the person who should accompany her during labor and birth, which must be treated with the utmost respect to feel empowered through the confidence of an accompaniment during the process of labor and TDP.

f. The intake of soft foods and/or liquids, prior assessment as long as there is no high risk or imminent risk of being converted to a surgical event as in the case of: partial placental abruption, placenta previa, hypoxia data fetal history, high fetal history, low fetal reserve or an urgent surgical event is anticipated in the short term, since the trans-surgical risk will be greater in the user who has taken some food due to the risk of bronchial aspiration and surgical risks.

g. Care by the perinatal nurse, midwife or ("Dula"), whose objective is to provide personalized care, while detecting if there is any risk factor in the binomial that converts a low-risk PDD into a high-risk one. When high risk is detected during the TDP, the necessary measures will be taken, among which referral to a second or third level of care can be considered in the event that the contingency or eventuality cannot be resolved at a first level, or it cannot be resolved. We have the necessary infrastructure in obstetric care centers.

h. The pain threshold is defined by meeting the expectations of the parturient in relation to pain relief, and may require massages in

certain regions of the pelvis, accompanied by movements and exercises in joints and muscles, as well as specific pain relief positions with application local heat with preheated bags that can be placed inside seeds that serve both to give massages and at the same time conserve heat in a specific area, and if it is not enough, analgesia or obstetric anesthesia can be used in special cases to reduce pain if the parturient requests it.

i. When analyzing the mobilization and adoption of different positions during the TDP, the parturient can wander during labor (prior assessment by the competent professional) and perform certain movements to favor the descent of the newborn through the birth canal.

j. Regarding the position of delivery, outcome of delivery, the user is able to decide in which position she wants to be attended, always carrying out the technique of asepsis and antisepsis and the protection of the patient and the newborn. And even though there are endless variants of childbirth such as vertical, kneeling, squatting, lifted by the shoulders by the husband, holding on to a rope hanging from a beam on the ceiling, leaning on a chair or on all fours (position crawling) in vertical delivery, it is estimated that the positive action of the forces of gravity favors the engagement and descent of the fetus through the maternal pelvis. The mother gains between 30-40mmHg of intrauterine pressure when she adopts the upright position (Méndez Bauer, 1976).

k. Allow the patient to choose the most comfortable position for delivery.

l. Non-pharmacological methods: immersion in hot water as a method to reduce pain relief during the 1st and 2nd stages of TDP, the use of kinesic balls (mobility support) to find anti-algesic positions and help the newborn descend through the birth canal. childbirth, aromatherapy and music therapy (relaxation, instrumental or background music according to the preferences of the parturient) and dim light help to promote a warm and comfortable environment during the PDD stage.[17]

m. Skin-to-skin contact: it is carried out immediately at the birth of the neonate, it is placed in a prone position in contact with the maternal skin between the thorax and the abdomen of the mother, transmitting body heat, a feeling of protection, attachment and security, helping regulation heat (Figure 2) and a favorable environment for the initiation of lactation, on the other hand, nipple sucking favors the release of oxytocin and maternal prolactin, favoring the production of breast milk by stimulating the receptors found in the nipple to which the hypothalamus-pituitary feedback process helps increase endogenous oxytocin, causing colostrum ejection and uterine contractibility in women, decreasing the risk of postpartum hemorrhage.

n. With the initiation of breastfeeding with attachment and skin-to-skin contact, the newborn is able to maintain a glycemia within normal parameters, favoring the initiation of his first colostrum intake, which is very useful immunologically. This action will be carried out as long as the newborn's adaptation allows it and there is no need to resort to neonatal resuscitation and even if it were, the woman is taught the technique of manual milk extraction, and be kept refrigerated with adequate hygiene measures, so that as soon as the newborn is able to drink breast milk, he can do so without any problem, which guarantees the benefits of exclusive breastfeeding and on free demand.

According to the clinical practice guide: Surveillance and management of labor in low-risk pregnancies (2014): in relation to late clamping of the umbilical cord, it is considered late when it is clamped after the cessation of funicular beating, between the event of the birth and the cessation of heartbeat from the placenta to the fetus can pass up to 100ml of blood to the fetus, (approximately 3 to 5 min) favoring oxygenation and hemodynamic balance, the ligation is performed 2 to 3 cm away from the base of the abdomen of the neonate and ligated with a clamp, special umbilical cord ligation or special ligature, keeping it as hygienically as possible, since if due to some circumstance of maladjustment of the newborn it can be an ideal and quick way to start intravenously with emergency medications in neonatal resuscitation. The stump should be washed with soap and water during the daily bath, recommending to the mother that it dehydrates and falls off in approximately 8 to 15 days, so it is extremely important to ensure that it does not ooze any foul-smelling substance or the Surrounded area is erythematous or with increased temperature, as this may indicate an infectious process that should be treated with the competent specialist.

Guarantee early approach and joint accommodation (stay 24 hours) mother-child, favoring early and exclusive breastfeeding except in the case of HIV positive screening referred to in Standard 010 of the International code of substitutes, where it specifies that if the mother is a carrier of the HIV virus, she should not breastfeed since it has been found that there is a 15% probability of being transmitted to the newborn med iante lactation, except in third world countries where there is no other resource to safeguard the life of the newborn is allowed under certain conditions (Figure 2). In May 2004, the celebration of humanized childbirth took place, carried out by several countries, added to an initiative of the French Association for respectful childbirth, promoted by UNICEF, the Pan American Health Organization and the Latin American Network and of the Caribbean for the Humanization of Labor and Birth.[18]

In 2012, the risk of dying from a cause related to pregnancy, childbirth and the puerperium was 5 times higher for women in the 100 poorest municipalities in Mexico[19] and 3 times higher for indigenous women.[20] Today, due to the constant training of health personnel, interns, nurses, nurses, and community midwives in rural areas, the maternal-infant mortality rate in marginalized and vulnerable areas has been greatly reduced.

According to Misago and Kendall, it is emphasized that in order to humanize a birth, it is necessary to "empower" the woman, forming her participation in making decisions about her self-care. On the other hand, health professionals must reinforce their resources based on technology and always promoting primary health care. In opposition to the use of technology and exorbitant medicalization, obstetric violence and invasive methods, the natural birth care process is often dehumanized.[21]

Davis-Floyd affirms that, by humanizing a birth, one becomes compassionate, sensitive, individual, rational, the care model, being a humanist, taking into account biology, psychology and the social environment, as well as recognizing the influence of the mind over the body, since being so associated and communicated, it is impossible to treat something physical without considering the psychological approach, which makes the woman visualize as a person and not just another patient or a bed number, establishing a connection human with her.[22] In recent times there were traumatic experiences between intervened or medicalized childbirth and humanized childbirth, knowing three types of maternity in the country: one with high standards of medicalization,[23] another where humanized childbirth

was practiced, and a third where both followed systems were combined. of different paradigms in each special case.[24]

The UN establishes "birth as a proposal that seeks to trace paths for peace and healing in the world" defining it as a cluster of values, attitudes and behaviors that evade the violence, at the same time empowering women based on rights, respect for life, their dignity, principles of freedom, justice, solidarity and tolerance.[25] While, for the physiological approach, childbirth is understood as a natural process that implies minimizing routine procedures and interventions, through humanized childbirth, always providing quality and warmth to the care process.[26] WHO (2018) "Approximately 140 million births occur each year in the world, most of them are low-risk and spontaneous."[27] According to INEGI (2016) reports, a total of 61.5 million women were reported in Mexico City, 53.3% of reproductive age (15 to 49 years) and 67.4% of women over 12 years of age have had a child, which 32.8 million need assistance for birth.[28] Next, other forms of humanized delivery care are addressed, such as water delivery and home delivery.

Water birth

Another variety of birthing is water birthing. In ancient times, water was used as a treatment for physical and mental illnesses by the Chinese, Egyptians, Japanese, Greeks, and Romans, with immersion in hot water regaining importance during PDT as a method of relaxation and momentary pain relief. Michel Odent made this technique popular in European countries, highlighting the benefits of buoyancy, which allows one to move more easily; another benefit was also the reduction of blood pressure as a consequence of arterial vasodilation, reduction of drugs for pain and analgesia. obstetric. Another favorable aspect is the release of endorphins and endogenous oxytocin, reducing stress and favoring the progression of PDD.[32]

The Law (No. 25929) "Humanized Childbirth Law protects the woman's decision to choose the place of delivery and we must be respectful of it, making women aware that there is less intervention in home births, compared to the caesarean sections, forceps, episiotomy and anesthesia, increasing the possibility of complications, this law also establishes that each person has the right to choose in an informed and free manner, the place and the way in which their labor, ambulation, position, analgesia, accompaniment and route of birth. The health team and the assisting institution must respect such a decision as long as it does not compromise the health of the mother-child pair."[33]

Home delivery

Home birth is one in which, given the favorable conditions of space and hygiene, the birth of the newborn is carried out in the home of the pregnant woman. Home birth is not synonymous with high risk, so exhaustive assessment in the prenatal stage and in pregnancy must be an adequate selection of who is a candidate for this model, added to an adequate planning of health professionals and families, who provide specific data of who is a candidate for a home delivery, the professional A trained health worker must have support networks, if necessary, make a hospital referral when a complication occurs, this will also provide confidence and security to the family and the parturient and is another model within respected childbirth, as well as childbirth. Ambulatory, vertical, in water, home, squatting, in four points.[34] This practice dates back to ancestral times where deliveries were carried out at the home of the parturient and then gave rise to assistance by the midwife of the town who assisted during childbirth. In Buenos Aires the SOGIBA (Society of Obstetrics and Gynecology of Buenos Aires) arises, it is made up of more than 1000 Gynecologists and Obstetricians of the City of Buenos Aires, who base their scientific ideas on women, whose work so far has shown relative significance in perinatal morbidity and mortality.

Methods

To carry out this narrative review, a bibliographical review was carried out to develop a reflective critical analysis of the content of documents on humanized childbirth and quality obstetric care in the 1st and 2nd level of care in Mexico, where theses, original articles and articles were considered. review, and experience in the practice of respected childbirth, so the search strategy adopted was the use of keywords or descriptors, connected through the boolean operator and the keywords used were "humanization", "childbirth", "Human needs" and "breastfeeding", identified through Medical Subject Headings 2020 Serach MeSH, the articles referred to descriptors in Spanish and English were used for the search. The search was carried out in various databases.

The search was carried out on websites such as: Scielo, PubMed, Google Scholar, Medline, among others, the inclusion criteria for the selection of scientific articles in both Spanish and English available on the mentioned digital portals, the criteria The exclusion criteria were similar or repeated investigations or that had no relation to the research topic. The 1) search for information began historically in pre-Hispanic times up to the present. No conflict of interest in its authors is reported in any article.

Humanized deliveries attended by health professionals are carried out under prenatal control with obstetric risk assessment. If necessary, the high-risk carrier in pregnancy was referred to a second or third level of care with due referral. It must be in written form and in an effective, prompt and timely manner, delimiting damage to the couple, avoiding perinatal morbidity and mortality, Information collection time 6 months, August 2022 to February 2023.

Conclusions

The review allowed us to analyze the historical evolution of humanized childbirth and the transcultural significance and regulations that it represents, as well as the structural components of which a humanized childbirth is integrated, and how it will reinforce the multidisciplinary health team that cares for women in this process. , to offer different strategies to make this stage an unforgettable and very much humanistic experience that you´ll never forget and you´ll be remembered as a loving and emotional experience.

Humanization in delivery care is a concept that goes beyond evidence-based medicine, perinatology, psychoprophylaxis, responsible paternity and maternity, the real meaning denotes all elements based on medical, paramedical, scientific, technologies, attitudes and convictions, thus achieving humanized childbirth, with all the accumulation of sensations, perceptions and emotional feelings, linked to the self-realization of the woman during the pregnancy process, beginning of labor, during childbirth and the puerperium, and initiation of lactation that will be relevant in the adherence of the binomial, taken a meaning of support, protection, thermal control of the newborn with skin-to-skin contact, glycemia control of the newborn and immediate initiation of breastfeeding, satisfying their human needs that are transmitted at all times through the protection, comfort, attachment, that the mother offers to the newborn, is e later will be a healthy person from the point of view biologically, psychologically and socially.

By raising awareness among the population so that the birth of a new being is an extraordinary and physiological process in which

the mother and the newborn are a leading part of an unforgettable event, free of trauma, stress and unpleasantness, making it a unique and invaluable in the woman who is about to give birth and have a unique experience in her reproductive life, which will remain recorded forever as a successful and relevant stage of her life.

Improving the quality of humanized childbirth care through quality standards of care for women in the reproductive stage at general level, and adapting assistance services to society through cultural diversity, preferences, human needs and respect for their beliefs. and needs, helps to a great extent to reduce maternal and neonatal morbidity and mortality rates, promoting humanized delivery care in low-risk care, reflecting the early incorporation into the family nucleus without complications and linking it to their normal life in a short time.

Today we know that care based on evidence and scientific knowledge is a component of humanized delivery care. Therefore, humanization continues to pose a challenge for the health professional, for the institutions that carry it out and for society, putting into practice the aspects that comprise humanized care, to achieve this it is necessary to base knowledge on practices of evidence and use ethical competencies such as respect and autonomy of women and their leadership, empathy and active listening, taking as a priority, being free from violence and unnecessary medicalization, giving comfort and humanization to the process of humanized childbirth care.

Care for women during pregnancy, childbirth and the puerperium with a humanized, intercultural and safe approach in Institutions motivated by this process, more and more are joining, such as: "CIMIGen", Women's Specialty Clinic, "Santa Catarina" Clinic, some maternity hospitals In the State of Mexico, such as the "Maternidad de Atlacomulco", "Clínica Cuautitlan", in some others, given their infrastructure and resources, sometimes humanized childbirth is not carried out 100%, but instead some strategies are carried out such as: dignified treatment, immediate attachment, late clamping, skin-to-skin contact, rooming-in, exclusive breastfeeding, carried out at: "General Hospital of Zone No. 47", "General Hospital of Troncoso zone", "General Hospital of Zone 1A", "Dr. . Rodolfo Antonio de Mucha Macias ", UMAE "Hospital de Gineco Obstetricia No. 4", "Hospital Gea González", "Hospital Regional de Tula Tepeji in Hidalgo", and in different states of the republic such as: Chihuahua, Durango, Queretaro, among many others, increasingly humanized childbirth is being implemented as a care model in more hospitals, clinics, and maternity Units, where a multidisciplinary team is cared for with high quality standards and warmth in 1st and 2nd Obstetric care. Level of care in Mexico, where they make this stage a unique and unforgettable experience for the couple.

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Conflicts of interest

No conflicts of interest.

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