

Humanizing childbirth care: a brief theoretical framework¹

Humanização na atenção a nascimentos e partos: breve referencial teórico

Humanización en la atención a nacimientos y partos: breve referencial teórico

Daphne Rattner²

ABSTRACT

In spite of increased coverage of prenatal care and hospitalized births, maternal mortality coefficients have stabilized at relatively high values. This is attributed here to inadequate care. One of the components of the process of care is interpersonal relationships and these have been associated with the concept of humanization. A strong international movement with increasing theoretical production can be identified, in which humanization of childbirth care is taken to be a response both to the mechanization of the way in which professional work is organized and to institutional violence. However, 'humanization' is a polysemic term, and the perspective that is adopted and the sense that is conferred need to be identified when this term is used.

KEYWORDS: Humanizing childbirth. Technology. Evidence based medicine.

RESUMO

Apesar da ampliação da cobertura da atenção pré-natal e hospitalização do parto, houve estabilização no coeficiente de mortalidade materna em valores relativamente altos,

1 Published originally in Portuguese in *Interface - Comunic., Saúde, Educ.*, v.13, supl.1, p.385-392, 2009. 8p. Translated by Maria Aparecida Gazotti Vallim. Revised by Robbie Davis-Floyd.

2 Médica epidemiologista. Universidade de Brasília, Departamento de Saúde Coletiva. Campus Universitário Darcy Ribeiro - Faculdade de Ciências da Saúde. Brasília - DF, 70910-900 - (55)61-3107-1951. E-mail: daphne.rattner@gmail.com.

atribuída aqui à qualidade inadequada da atenção. Um dos componentes do processo de assistência é a relação interpessoal, à qual tem sido associado o conceito de humanização. Identifica-se um forte movimento internacional que aborda a humanização da atenção a nascimentos e partos como uma resposta à mecanização na organização do trabalho profissional e à violência institucional, com crescente produção teórica. Todavia, o termo é polisêmico e faz-se necessário, ao deparar-se com a expressão, identificar que perspectiva está sendo adotada e qual o sentido que lhe é conferido.

PALAVRAS-CHAVE: Parto humanizado. Tecnologia. Medicina baseada em evidências.

RESUMEN

A pesar del aumento de la cobertura de la atención pre-natal y hospitalización del parto el coeficiente de mortalidad materna todavía se mantiene en valores relativamente altos, debido a la inadecuada calidad de la atención. Uno de los componentes del proceso de asistencia es la relación interpersonal, el cual está asociado al concepto de humanización. Existe un movimiento internacional fuerte que aborda la humanización de la atención a los nacimientos y partos como respuesta a la mecanización de la organización del trabajo profesional y a la violencia institucional así como se observa un aumento de la producción teórica. Humanización es un término polisémico, siendo necesario identificar cual es la perspectiva que está siendo utilizada y el sentido dado.

PALABRAS-CLAVE: Parto humanizado. Tecnología. Medicina basada en evidencias.

The human being and the “birth machine”

At the beginning of the last century, childbirth was mostly attended at home by midwives. Families had many children, so that some of them could resist the difficult living conditions of that time, and there were no antibiotics to prevent and cure infections. From the 1940s on there was a growing trend for hospital births, and at the end of the 20th century more than 90% of births were carried out in hospitals in the developed world. With advances in antibiotic therapy and in the availability of technological means for diagnostics and therapeutics, as well as with improvements in living conditions, we have achieved a real reduction in maternal and neonatal mortality. Nevertheless, in the last twenty years maternal mortality has remained constant in Brazil and much higher than that of developed countries, regardless of knowledge advancements, of new technologies, and of incorporation of essential support.

In spite of improvements in the quality of information and of increased access to prenatal care by means of the Family Health Strategy or more access to hospital birth, the tendency to maternal mortality stabilization in Brazil around 55 per hundred thousand live births (or 75 per thousand live births, if applied the correction factor of 1.4) can still be explained by issues mainly related to access to services with quality care in pregnancy, in childbirth and in postpartum. It stands out that all the analytical work on that mortality rate has identified that over 90% of these deaths could be avoided in developing countries. It is therefore necessary to reflect on the reasons for rate stability.

The twentieth century has witnessed a growing enthusiasm for the possibilities of industrial development, which has influenced all sectors of human activity. In the health sector, the technical component was privileged over the care component, and the mechanical or industrial rationality, just because of productivity, was applied to the understanding of many aspects of care, as exemplifies an extract of a textbook in Public Health Administration: 42 // *Rev Tempus Actas Saúde Col*

“As an analogy, the human body may be considered similar to a machine. Its proper function depends on various physical and biochemical components. It might be compared to an internal combustion engine with limbs in place of pistons and the endocrine system acting as carburetor. Superimposed is the supervisory function of the human mind. In like manner, the human body may be regarded as an economic unit brought into existence for measurable, potential, productive purposes”¹.

For Braga², this industrial and technical approach regarding health care has also contributed to the development of hospitals as privileged places for health service provision. These establishments were able to centralize sophisticated and expensive equipment, as well as qualified technicians to use them, besides increasingly specialized and sub-specialized doctors. Hence, assistance could be organized as a production line - so much so that in the United States the term “health care industry” is common. The theory of hospital administration adapted an industrial understanding to assistance, naming the users *input* - raw material, the process as *throughput*, and the result as *output*, therefore ignoring the humanistic component of care. And according to the classic triad proposed for evaluation of quality (structure-process-result), one of the components of the process of care is the interpersonal relationship between patient and caregiver, to which has been associated the concept of humanization.

Birth assistance, even if “*giving birth is neither a disease nor a pathological process*”³, has also followed the industrial standard, and some maternity hospitals that schedule cesareans as if they were an *assembly line* of births, for the convenience of professionals and institutions, boasting from 70% up to 100% of cesarean birth rates, are good examples of this interpretation of time savings and productivity. On the other hand, an epidemiological study showed a clear association between the variation of economic

and market indicators, such as market potential and bank agencies per inhabitants, and the variation in cesarean birth rates⁴, suggesting that this surgical procedure has also acquired the characteristics of a commodity.

Lo Cicero⁵ focuses on the psychological aspects of interaction between parturients and obstetricians, which would be modulated by gender relations, since the approach to care follows a male logic and many obstetrical care providers are male, and during childbirth care a strong female vulnerability is exposed, allowing the expression of that difference. Oppressing the parturient has become a tradition in institutions, with phrases such as “*At the time you made that baby, you did not scream like that ...*”. A study by D’Oliveira et al.⁶ identified four forms of violence that happen in the birth setting: (1) violence by negligence, (2) verbal abuse and/or psychological violence, and (3) physical and (4) sexual violence, greatly contributing to build in the imaginary of the society a vision of labor and birth as traumatic and painful experiences. *Institutional* violence during birth is beyond the scope of this study, but we believe that the mechanized focus of the process adds a kind of violence that we could call depersonalizing. In many services, this depersonalization is exacerbated by stripping the woman of her belongings on admission (belongings such as glasses, rings, earrings, dentures and personal clothing) and demanding that she wear a gown that partly covers and partly exposes her body - practices which are typical of what Goffman⁷ called ‘total institutions’. Gomes et al.⁸ expose how this structural, institutionalized and symbolic violence is performed, taking as an example the process of admission to a general hospital in Northeast Brazil. Pizzini⁹ on the other hand, presents the medicalization, desexualization and depersonalization processes during the service delivery as a drama with prologue, first, second and third acts, and epilogue.

The dehumanized and mechanized view has been uncritically adopted in the academy, and the professionals incorporate it during

their formal education, since one of the most traditional Brazilian textbooks of obstetrics uses the metaphor “*engine-object-path*” to explain the mechanisms of birth: the uterus would be the engine, the fetus would be the object and the vaginal canal would constitute a path¹⁰ - a reduction that ignores the human beings involved and the richness of this process that, besides being biological, has been addressed as a cultural, social, sexual and spiritual phenomenon in a holistic approach^{11,12}.

Marsden Wagner¹³ was, for many years, the responsible agent for perinatal care in the World Health Organization Office in Europe and actively participated in the organization of the historical Conference on Appropriate Technology for Birth, held in 1985 in Fortaleza, whose recommendations were published right after that conference in *The Lancet*¹⁴. In his book *Pursuing the Birth Machine: The Search for Appropriate Birth Technology*, Wagner¹³ criticizes that mechanical approach and its practical consequences, besides describing WHO initiatives to build consensus around policies for perinatal care. Emily Martin¹⁵ also identifies metaphors of production process and assembly line present in the discourse about birth both in obstetric books and in obstetric practice.

Some understandings of humanization in labor and birth

In an important work of reflection, Diniz¹⁶ explains the possible meanings of the term “humanization” in her research on maternity hospitals in São Paulo, and mentions that each term makes a claim of discourse legitimacy explicit, although there may be an overlap between them. After analyzing the data collected, she reached the following analyses of the polysemic attributes of “humanization”:

a) **Humanization as scientific legitimacy of medicine, or assistance based on evidence, considered as the gold standard.** According to that reading, the practice is guided by the concept of appropriate technology and of

respect for physiology. She comments that “in the activists’ interpretation, humanization in childbirth assumes that the technique is also political in nature and that in the routine procedures - immobilization, induction of labor, unnecessary cuts, loneliness and helplessness - are ‘embodied’ social relations of inequality: gender, class and race inequality, among others.” In that case, there is a political appropriation of technical discourse – what she considers a strategy not exempt of risks.

b) Humanization as the *political legitimacy of claim and defense of women’s (and children’s, families’) rights in assisting birth* - or an assistance based on rights demanding care that promotes a safe labor, but also requiring a non-violent support related to the ideas of “humanism” and “human rights”. According to that understanding, users have the right to know and to decide upon obstetric procedures when there are no complications. This would constitute a more diplomatic strategy than talking about gender violence and birth violence, allowing a dialogue with healthcare professionals. Among those rights are: the right to corporal integrity (not suffering avoidable harm); the right to personhood (the right to informed choice re procedures); the right to be free of cruel, inhuman or degrading handling (prevention of physically, emotionally or morally painful procedures); the right to equity as defined by the Unified Health System (Sistema Único de Saúde - SUS). This approach aims to compose an agenda that combines social rights with reproductive and sexual rights and is based on the claims of the women’s movement.

c) Humanization as the result of adequate technology for the population’s health. According to the author, once appropriate care offers better results for *individuals*, a collective dimension becomes involved in terms of public policies, in the sense of *epidemiological legitimacy* - technological appropriateness resulting in better results with fewer maternal and perinatal iatrogenic injuries. That sense

becomes more important because of increased evidence that excessive interventions lead to increased morbidity and maternal and neonatal mortality. Reduction of iatrogenic interventions would be a way of health promotion: “The aim of the care is to achieve a healthy mother and child with the least possible level of intervention that is compatible with safety. This approach implies that in normal birth there should be a valid reason to interfere with the natural process”¹⁷.

d) Humanization as a *professional and corporate legitimacy of roles and powers that re-dimension the role of the participating actors in the childbirth scene.* That understanding represents a new and evidence-based understanding of the appropriate role of the surgeon-obstetrician in natural childbirth—his or her role should be to treat cases of true pathology in birth, leaving all normal births to the care of professional midwives trained in supporting the normal physiology of labor and birth – and in Brazil this was legitimized by the payment of that procedure in the healthcare system by the Brazilian Ministry of Health. Removing primary birth care from the obstetrical purview would entail moving the privileged place of birth from the surgical center to the delivery room or birth center, following the Scandinavian and Japanese Maternity Home care models. That perspective involves corporate and resource disputes and has been a field of a huge conflict, since doctors feel their work field is being invaded, and react in several ways, such as the Medical Act bill being proposed by the medical corporation in Brazil, which would create an impasse in the care model change project if effected in the originally proposed way.

e) Humanization referred to as *financial legitimacy of care models, that is, rationality in the use of resources.* That sense is used both as a disadvantage (by adopting nurses instead of physicians, one would be saving resources and not giving proper care for the poor, the “poor medicine for the poor”) and as

an advantage (using adequate technology and adequate resources, saving scarce resources, providing a broader action range and less spending on unnecessary procedures and their complications).

f) Humanization as the legitimacy of the parturient's participation in decisions about her health with improved user-professional relationship. This perspective emphasizes the importance of dialogue and the inclusion of either the father or a doula as a companion at the birth, and negotiation on the routine procedures. In this approach, the liberal tradition prevails - the tradition of the consumer's right to choose, emerging a "humanized care private network" and reiterating the legitimacy of Evidence-Based Medicine which was restricted to the public sector.

g) Humanization as the right to pain relief, as the right of patients who attend the public health care system to be included in the use of procedures known as humanitarian and previously restricted to patients of the private sector. This is a more common approach among doctors less close to the attributes of humanism that are based on scientific evidence or on the other rights of parturient women described above. For such doctors, "humanization" is synonymous with labor analgesia access. The author reminds us that childbirth pain can be enhanced by measures that iatrogenize it, such as loneliness, immobilization, misuse of oxytocin, Kristeller maneuver, unnecessary episiotomy and episiorrhaphy, among others.

Finally, the author comments that *humanization* is a less accusatory and strategic term than "institutional violence" to use in discussions with healthcare professionals about improvements in care.

We believe it is possible to correlate these differing senses of legitimacy re "humanization" through emphasizing aspects they have in common, following the example of scientific legitimacy and of the legitimacy of rational use

of technologies (a+c); the political legitimacy of rights defense, recognizing sexual and reproductive rights as human rights; and the legitimacy of parturients' participation in making decisions related to their bodies, which were historically constituted as an evolution of women's movements demands (b+f); and professional legitimacy, which is based on the model of care discussion and may be related to the epidemiological logic, as it is shown below (c+d).

The National Policy on Humanization/NPH (Política Nacional de Humanização/PNH) of the Brazilian Ministry of Health adopts a comprehensive perspective for understanding the term "humanization" and integrates several dimensions into that term, because the Ministry understands that "in the health field, humanization concerns an ethical-aesthetic-political bet: ethical because it implies the engaged and co-responsible attitudes of users, managers and healthcare professionals; aesthetic because it is related to the process of health production and of protagonists autonomous subjectivities; and political because it refers to the social organization of care and management practices in the Unified Health System network"¹⁸.

The NPH conceptualizes humanization as valuing different subjects involved in the health production process (users, workers and managers), emphasizing: the autonomy and the protagonism of those subjects, shared responsibility among them, the establishment of solidarity bonds, and collective participation in the management process. This conception implies changes in the care model, and therefore in the management model, focusing on citizens' needs and on health production. Thus, it establishes that humanizing birth should entail: commitment to the ambience, working conditions and health care attendance improvement; respect for issues related to gender, ethnicity, race, sexual orientation and specific populations (Indians, maroons, riverines, settlers, etc.); strengthening of

multiprofessional teamwork, fostering transversality and groupality; supporting the construction of networks that are cooperative, solidary and committed to health production and to subjects' production; strengthening of social control, meaning a participatory nature in all management instances of the Unified Health System; and commitment to the democratization of labor relations and valorization of healthcare professionals, stimulating ongoing education processes¹⁹.

Discussion

Deepening the first interpretation of *scientific legitimacy*, it is worth pointing out that the majority of professionals of healthcare facilities that care for childbirth adopted practices as they were being created, without submitting these practices to any evaluation criteria. In the 1990s, a movement in medicine was intensified, named Evidence-Based Medicine, which has been widespread by the World Health Organization (WHO). Its origin is due to the proliferation of diagnostic and therapeutic techniques and ultimate verification, after years of use, that many of them were ineffective or even caused more serious problems than those they were intended to treat. In the field of perinatal care, the WHO Reproductive Health Library, working in partnership with the Cochrane Collaboration²⁰, studied the practices adopted in childbirth care, thereafter publishing a manual¹⁷, which classifies the recommendations on practices related to normal birth into four categories: Group A. Practices which are demonstrably useful and should be encouraged; Group B. Practices which are clearly harmful or ineffective and should be eliminated; Group C. Practices for which insufficient evidence exists to support a clear recommendation and which should be used with caution while further research clarifies the issue; and Group D. Practices which are frequently used inappropriately.

In parallel, there was a convergence between the biological sciences and the humanities,

with anthropological studies on childbirth care models. Anthropologist Robbie Davis-Floyd^{11,12}, a North American educator with international reputation and prestige, typified those models as "technocratic," "humanistic" and "holistic". The technocratic model was adopted in the Western world, especially in the Americas, and is characterized by the institutionalization of birth, by the uncritical use of new technologies, and by the incorporation of a large number of interventions (often unnecessary), and ends up preferably meeting the convenience needs of healthcare professionals. Some of the consequences of that model are high rates of cesarean section, fetal monitoring and episiotomies, among others. The humanistic model emphasizes the parturient's and the baby's welfare, trying to be the least invasive. It uses technology appropriately and birth assistance is characterized by compassionate care during the labor process. In that model, in addition to hospitals, childbirth can both occur in birth centers and in ambulatories, and hospitals are reserved for cases where complications are really expected so as to reduce the transference time from the normal birth sector to the surgical birth sector.

The presence of companions is encouraged and the parturient can choose the position she finds more comfortable to labor in and to give birth. In that model, the professional of choice is the midwife (*parteira, sage-femme, Hebamme, madrona*), who is responsible both for monitoring the labor process and for the early detection of problems, when she then indicates removal to a referral institution with better conditions to attend the parturient. That model has long been adopted, and recently renewed, in some European countries, such as The Netherlands, Sweden, Switzerland, Germany, England, Norway, Denmark, and Finland, and also in New Zealand. In England, a country that steers the functioning of its health system by guidelines based on scientific evidence, the Secretary of State for Health of the United Kingdom (position equivalent to the Minister of Health) published in 2006 a public

policy that stated: “A strategic shift towards more home births is part of the Government’s move for more care to be provided in the community and in the home, and away from acute hospitals”²¹. Those guidelines are part of the movement of deinstitutionalization and towards home care as a response of the health care system to the increase of hospital infections by multiresistant bacteria and may indicate a transition from the humanistic model to the holistic model. The discussion about model of care strengthens the sense of corporate and professional legitimacy. And the holistic model is guided by individualized care and it incorporates the focus of birth and labor as events of spiritual life, in addition to understanding birth as a biological, cultural, social and sexual event.

In Brazil, it was interesting to notice that many of the practices adopted by the professionals who advocated the model of humanized care were countersigned by scientific evidence and were classified in Group A. For example, nowadays it is recognized that the presence of a companion of the woman’s choice is the best “technology” available for a successful birth: women who had continuous emotional support during the process of labor and childbirth were less likely to receive analgesia, to have an operative birth, and reported higher satisfaction with the experience of childbirth. That emotional support was associated with bigger benefits when those who provided it were not a member of the hospital staff and when it was available from the beginning of the labor process²². From those evidences derives the 11.108/2005 Law, named the Companion Law²³.

On the other hand, many of the routinely adopted practices in the maternity hospitals were classified in Group B, such as: routine public shaving, routine use of enema, fasting, routine intravenous infusion or routine use of the supine position during labor. Finally, cesarean section and episiotomy, for example, were classified in Group D^{20,17}.

International evaluations of health care models show that countries that maintained the humanistic childbirth care model, valuing the midwives or nurse-midwives’ role, such as the Scandinavian countries, England, Japan, The Netherlands, France, and Germany, among others, have managed to maintain their maternal and fetal/neonatal mortality and morbidity indicators low, as well as their interventions rates- cesarean sections, episiotomies etc. Childbirth care in those countries is based on respect both for the normal physiology of birth and the dignity of the woman and her family. Because pregnancy and childbirth are seen as normal physiological processes, parturient women can receive care at the primary care level. The birth can occur at home, in an ambulatory, in birth centers, and at the hospital. Moreover, in the previously mentioned countries, uncomplicated births are attended by a professional midwife who respects the intimacy of families and who plays an important role in crucial moments of life - such as labor and birth. Besides, the midwife becomes a personal reference for the families she cared for, a bonding that is recommended by the National Humanization Policy in Brazil. The option for that professional for normal childbirth care is endorsed by a recent publication of the Cochrane Collaboration²⁴.

It should be noted that the reflection of the present study addresses the different meanings of humanization, specifically in childbirth and labor care fields. The NPH humanization concept is transverse to the several senses listed, incorporating issues regarding: ambience, universality, process of work, management system, social control, subjectivities of caregivers and of care receivers, among other relevant aspects. The proposed ethical-aesthetic-political bet is a societal project based on equity, where access to health services with humanization and quality reflects the reassurance of citizenship in a democratic society.

Final considerations

The stabilization of the maternal mortality rate is certainly associated with inadequate quality of care, given the prevalent deficiency in the care component of the health care process. One aspect of that component is the interpersonal relationship, which is strongly associated with humanization. This paper has underlined an important international movement that identifies humanization of childbirth and labor care as a response both to the mechanization in professional work organization and to institutional violence, with increasing academic production. However, as we have shown, "humanization" is a polysemic term and when one comes across that term, it is essential to identify which perspective is being adopted, as well as what meaning is being conferred to it.

References

1. Hanlon JJ, Pickett GE. Public health: administration and practice. St. Louis: Times Mirror; Mosby College Publishing; 1984. p. 27.
2. Braga JC, Paula SG. Saúde e previdência: estudos de política social. 2. ed. São Paulo: Hucitec; 1986.
3. Wagner M. Getting the health out of people's daily lives. *Lancet*. 1982;(8309):1207-8.
4. Rattner D. [On the hypothesis of the cesarean birth rates stabilization in south eastern, Brazil]. *Rev Saúde Pública*. 1996;30(1):19-33.
5. Locicero AK. Explaining excessive rates of cesareans and other childbirth interventions: contributions from contemporary theories of gender and psychosocial development. *Soc Sci Med*. 1993;(37):1261-9.
6. D'Oliveira AFPL, Diniz CS, Schraiber LB. Violence against women perpetrated within health care institutions: an emerging problem. *Lancet*. 2002;(359):1681-5.
7. Goffman E. Manicômios, prisões e conventos. São Paulo: Perspectiva; 1985.
8. Gomes AMA, Nations MK, Luz MT. Pisada como chão: experiência de violência hospitalar no Nordeste brasileiro. *Saude Soc*. 2008;17(1):61-72.
9. Pizzini F. The expectant mother as patient: a research study in Italian maternity wards. *Health Promotion*. 1989;4(1):1-10.
10. Rezende J. Obstetrícia. 6. ed. Rio de Janeiro: Guanabara Koogan; 1992.
11. Davis-Floyd R, St. John G. From doctor to healer: the transformative journey. New Jersey: Rutgers University Press; 1998.
12. Davis-Floyd R. The technocratic, humanistic, and holistic models of birth. *International Journal of Gynecology & Obstetrics*. 2001;75 Suppl 1:S5-S23.
13. Wagner M. Pursuing the birth machine: the search for appropriate birth technology. Camperdown: ACE Graphics; 1994.
14. Organização Mundial da Saúde. Appropriate technology for birth. *Lancet*. 1985;2(8452):436-7.
15. Martin E. A mulher no corpo: uma análise cultural da reprodução. Rio de Janeiro: Garamond; 2006.
16. Diniz CSG. Humanização da assistência ao parto no Brasil: os muitos sentidos de um movimento. *Cienc. Saúde Colet*. 2005;10(3):627-37.
17. Organização Mundial da Saúde. Care in normal birth: a practical guide. Geneva: World Health Organization; 1996. p. 4. OMS/SRF/MSM/96.24.
18. Brasil. HumanizaSUS: Política Nacional de Humanização. Brasília. CD-ROM.
19. Ministério da Saúde (Brasil). HumanizaSUS: Política Nacional de Humanização: documento base para gestores e trabalhadores do SUS. Brasília: Ministério da Saúde; 2004.
20. Enkin M, et al. A guide to effective care in pregnancy and childbirth. 3. ed. Oxford: Oxford University Press; 2000.
21. Woolf M, Goodchild S. Childbirth revolution: mummy state: more women should have babies at home, not in hospital, says Health Secretary. *The Independent*, London, 14 maio 2006 [citado 2009 Jun 18]. Disponível em: <http://news.independent.co.uk/uk/health_medical/article448999.ece>.
22. Hodnett ED, et al. Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*. 2007;(3). Art. n.: CD003766. DOI: 10.1002/14651858.CD003766.pub2.
23. Brasil. Lei 11.108, de 7 de abril de 2005. Altera a Lei 8.080, de 19 de setembro de 1990, para garantir às parturientes o direito à presença de acompanhante durante o trabalho de parto, parto e pós-parto imediato, no âmbito do Sistema Único de Saúde - SUS. *Diário Oficial da União*, Brasília, 8 abr. 2005. Seção 1, p.1.
24. Hatem M, et al. Midwife-led versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*. 2008;(4). Art. n.CD004667. DOI:10.1002/14651858.CD004667.pub2.

Artigo apresentado em 12/07/2010

Aprovado em 30/08/2010

Traduzido em 16/10/2010

Gender, maternal health and the perinatal paradox¹

Gênero, saúde materna e o paradoxo perinatal

Género, salud materna y la paradoja perinatal

Simone Grilo Diniz²

RESUMO

ABSTRACT

In the last 20 years there was an improvement in access to services and in almost all maternal health indicators in Brazil. Paradoxically, there is no evidence of improvement in maternal mortality. This paper aims to help to understand this paradox, by analyzing the typical models of care in childbirth in public (SUS) and private sectors; the proposals for change based on evidence and on women's rights; and the conflicts of interest and resistance to change. We review the gender biases in research and in programming, especially the overestimation of the benefits of technology, and the underestimation, or the denial, of adverse effects and discomforts of interventions. Beliefs based in sexual culture are often accepted as 'scientific' explanations of the body, sexuality and the birth physiology, and are reflected in the imposition of unnecessary risk and suffering, in practices that are harmful for genital integrity, and in the denial of the right to companions in delivery. This 'pessimization of birth' is instrumental to promote, comparatively, the model of routine section. Finally we describe how the use of gender as analytical category can contribute to promote rights and cultural changes, as in the case of companions in childbirth.

KEYWORDS: Gender. Sexual and reproductive health. Evidence-based care. Unified Healthcare System. Maternal health. Humanization.

Nos últimos 20 anos, houve uma melhoria de praticamente todos os indicadores da saúde materna no Brasil, assim como grande ampliação do acesso aos serviços de saúde. Paradoxalmente, não há qualquer evidência de melhoria na mortalidade materna. Este texto tem como objetivo trazer elementos para a compreensão deste paradoxo, através do exame dos modelos típicos de assistência ao parto, no SUS e no setor privado. Analisaremos as propostas de mudança para uma assistência mais baseada em evidências sobre a segurança destes modelos, sua relação com os direitos das mulheres, e com os conflitos de interesse e resistências à mudança dos modelos. Examinamos os pressupostos de gênero que modulam a assistência e os vieses de gênero na pesquisa neste campo, expressos na superestimação dos benefícios da tecnologia, e na subestimação ou na negação dos desconfortos e efeitos adversos das intervenções. Crenças da cultura sexual não raro são tidas como explicações 'científicas' sobre o corpo, a parturição e a sexualidade, e se refletem na imposição de sofrimentos e riscos desnecessários, nas intervenções danosas à integridade genital, e na negação do direito a acompanhantes. Esta 'pessimização do parto' é instrumental para favorecer, por comparação, o modelo da cesárea de rotina. Por fim, discutimos como o uso da categoria gênero pode contribuir para promover direitos e mudanças institucionais, como no caso dos acompanhantes no parto.

PALAVRAS-CHAVE: Gênero. Saúde sexual e reprodutiva. Cuidado baseado em evidências. Sistema Único de Saúde. Saúde materna. Humanização.

RESUMEN

En los últimos 20 años mejoraron prácticamente todos los indicadores de salud materna en el Brasil, así como hubo un amplio acceso a los servicios de salud.

¹Published originally in Portuguese in: Rev Bras Crescimento e Desenvolvimento Hum. 2009; 19(3):313-326. Translated by Karem Heitor Girão. Revised by Simone Diniz.

² Departamento de Saúde Materno-Infantil. Faculdade de Saúde Pública. Universidade de São Paulo. Av. Dr. Arnaldo, 715 - sala 218 - CEP 01246-904. São Paulo, São Paulo - Brasil. E.mail: sidiniz@usp.br