Interface vol.4 no.se Botucatu 2008

Humanizing childbirth care: brief theoretical framework

Humanização na atenção a nascimentos e partos: breve referencial teórico

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

Daphne Rattner

Área Técnica de Saúde da Mulher, Departamento de Ações Programáticas e Estratégicas, Secretaria de Atenção à Saúde, Ministério da Saúde. Esplanada dos Ministérios, bloco G, sala 629. Brasília, DF, Brasil. 70.058-900 <daphne.rattner@gmail.com>

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, 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 polissêmico 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 de la ampliación de cobertura de la atención prenatal y hospitalización del parto, el coeficiente de mortalidad materna se ha estabilizado en valores relativamente altos, lo que aquí se atribuye a la calidad inadecuada de la atención. Uno de los componentes del proceso de asistencia es la relación interpersonal a la cual se ha asociado el concepto de humanización. Se identifica un fuerte movimiento internacional que plantea la humanización de la atención a nacimientos y partos como una respuesta a la mecanización en la organización del trabajo profesional y a la violencia institucional, con creciente producción teórica. No obstante el término es polisémico y se hace necesario, al deparar con la expresión, identificar la perspectiva que se adopta y el sentido que se le confiere.

Palabras clave: Parto humanizado. Tecnología. Medicina basada en evidencias.

The human being and the "birth machine"

At the beginning of last century, childbirth was mostly attended at home by midwives. The 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 forties there was a growing trend for hospital births, and at the end of last century more than 90% of births were carried out in hospitals. With advances in antibiotic therapy and in the availability of technological means for diagnostics and therapeutics as well as with the improvement in the 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 and of new technologies 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 with the possibilities of industrial development, which 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:

> As an analogy, the human body can be considered similar to a machine. Its proper functioning depends on several physical and biochemical components. It can be compared to an internal combustion engine with members instead of pistons and with the endocrinous system acting as a carburetor. It is super-imposed on the oversight function of the human mind. Similarly, the human body can be faced as a human unit whose existence has productive, potential and measurable purposes (Hanlon, Picket, 1984, p.27).

For Braga and Paula (1986), this industrial and technical approach regarding health care has also contributed to the development of hospitals as privileged places for the 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 it is usual the denomination of health care industry *(Health Services Industry)*. The theory of hospital administration adapted to the 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, to which has been associated the concept of humanization.

The births' assistance, even if "giving birth is neither a disease nor a pathological process" (Wagner, 1982, p.1207), has also followed the industry standard and some maternity hospitals that schedule cesareans as if they were a *production 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 rates (Rattner, 1996), suggesting that this surgical procedure has also acquired characteristics of consumer goods.

Lo Cicero (1993) focuses on the psychological aspects of interaction between parturients and obstetricians, which would be modulated by gender relations, since the approach to service 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. It is already a tradition the oppression on the parturient in institutions with phrases such as *"At the time you did it, you did not scream ..."*. A study by D'Oliveira et al. (2002) identified four violence forms that happen in the birth setting: the violence by negligence, the verbal abuse and/or psychological violence, the physical and sexual violence, greatly contributing to build in the imaginary of the society a vision of labor and birth as traumatic and painful experiences. The approach of 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 demand her to wear a nightdress that partly covers and partly exposes her body - practices which are typical of what Goffman called 'total institutions' (1985). Gomes et al. (2008) expose how that structural, institutionalized and symbolic violence is performed, taking as example the process of admission to a general hospital in Northeast Brazil. Pizzini (1989), 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 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 path (Rezende, 1992) - 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 (Davis-Floyd, 1998).

Marsden Wagner was, for many years, the responsible for perinatal care in the World Health Organization Office in Europe and actively participated in the organization of the anthological Conference on Appropriate Technology for Birth, held in 1985 in Fortaleza, whose recommendations were published right after that Conference in The Lancet (WHO, 1985). In his book *Pursuing the Birth Machine: The Search for Appropriate Birth Technology*, Wagner (1994) criticizes that mechanical approach and their practical consequences, besides describing WHO initiatives to build consensus around policies for perinatal care. Emily Martin (2006) 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, Diniz (2005) explains the possible meanings that the term humanization has in his 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, he had the following outcome:

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 - in immobilization, in induction of labor pains and of unnecessary cuts, in loneliness and in 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 the birth procedures without complications. It would be 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 on procedures); the right to be free of cruel, inhuman or degrading handling (prevention of physically, emotionally or morally painful procedures); the right to equality 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 it is based on the claims of the women's movement.

c) Humanization referred to the result of adequate technology for the population's health. According to the author, once the appropriate care offers better results for *individuals*, that incurs in a collective dimension with the claim of public policies in the sense of *epidemiological legitimacy* - the technological appropriateness resulting in better results with fewer maternal and perinatal iatrogenic injuries. That sense becomes more important insofar there is an increase in evidence that excessive interventions lead to increased morbidity and maternal and neonatal mortality. The 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." (World Health Organization, 1996, p.4).

d) Humanization as a *professional and corporate legitimacy* of roles and powers resizing of the participating actors in the childbirth scene. That understanding represents the role of the surgeon-obstetrician's displacement as the exclusive caregiver in natural childbirth to the nurse-midwife - legitimized by the payment of that procedure by the Ministry of Health. It also moves the privileged place of birth from the surgical center to the delivery room or birth center, following the European and Japanese care models. That perspective involves corporate and resources disputes and has been a field of a huge conflict, since doctors feel their workfield invaded and react in several ways, like the Medical Act bill which would create an impasse in the care model change proposal 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 (saving resources and not giving proper care for the poor, the "medicine for the poor") and as an advantage (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 their health* with improved user-professional relationship. There is emphasis on the importance of the dialogue and on the inclusion of either the father or a doulas as a companion at the birth, and there is negotiation on the routine procedures. In that approach prevails the liberal tradition, 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 to patients who attend the public health care system be included in the use of procedures known as humanitary and previously restricted to patients of the private sector. That is a more common approach among doctors less close to the ideas based on evidences or on rights. For them, humanization is synonymous to labor analgesia access. The author reminds 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 to talk with healthcare professionals about institutional violence.

We believe it is possible to correlate those different senses of legitimacy in aspects they have in common, following the example of the scientific legitimacy and of the rational use of technologies legitimacy (a+c); the political legitimacy of rights defense, recognizing sexual and reproductive rights as human rights, and the legitimacy of the parturients' participation in taking decisions related to their bodies, which were historically constituted as an evolution of women's movements demands (b+f); and the professional legitimacy, which is based on the care model discussion and it is related to the epidemiological logic, as it is shown below (c+d).

The National Humanization Policy/NHP (Política Nacional de Humanização/PNH) of the Ministry of Health adopts a comprehensive perspective for understanding the term humanization and integrates several dimensions to it, since it 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" (Brasil, n.d.).

The NHP 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 the collective participation in the management process. It implies changes in the care model, therefore in the management model, focusing on the citizens' needs and on the health production. Thus, it establishes that in order to have humanization should have: commitment to the ambience, working conditions and health care attendance improvement; respect to 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 which are cooperative, solidary and committed to health production and to subjects' production; strengthening of social control with 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 processes (Brasil, 2004).

Discussion

Deepening the first interpretation of scientific legitimacy, it is worth pointing out that the majority of the service delivery adopted practices occurred as they were being created, without being submitted to an evaluation criteria. In the nineties of last century, 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 diagnostic and therapeutic techniques proliferation, and it was verified, 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, it was created the WHO Reproductive Health Library that, working in partnership with the Cochrane Collaboration (Enkin et al., 2000), studied the practices adopted in attending service delivery and childbirth, thereafter publishing a manual (World Health Organization, 1996) 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.

Parallelaly, there was a convergence between the biological sciences and the humanities, with anthropological studies on childbirth care models. The anthropologist Robbie Davis-Floyd, North American educator with international reputation and prestige, typified those models as technocratic, humanistic and holistic (1998). 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 (many times unnecessary), and ends up preferably meeting the convenience needs of healthcare professionals. Some of the consequences of that conception are the high cesarean section rates, fetal monitoring, 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 the assistance is characterized by a continuous monitoring of the labor process. In that conception, 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 have her child. In that model, the professional chosen is the midwife *(midwife, sage-femme, Hebamme)*, who is responsible both for monitoring the labor process and for the early detection of problems, when she then indicates removal to an institution with conditions to attend the parturient. That model is still adopted in many European countries, such as Netherlands, Sweden, Germany, England and France, and also in Japan. In England, a country that guides the operation 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 said: "a strategic shift towards more home births is part of the movement of government so that more health assistance be offered in the community and in the home, and away from hospitals" (Woolf, Goodchild, 2006). Those guidelines are part

of the movement of deinstitutionalization and towards home care as a response of the health system to the increase of hospital infections by multiresistant bacterias and may indicate a transition from the humanistic model to the holistic model. The discussion of care model 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 the spiritual life, in addition to understanding the 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 labor process and childbirth were less likely to receive analgesia, to have operative birth, and reported stronger satisfaction with the experience of childbirth. That emotional support was associated with bigger benefits when those who provided it was not a member of the hospital staff and when it was available since the beginning of the labor process (Hodnett et al., 2007). From those evidences derives the 11.108/2005 Law, named the Companion Law (Brasil, 2005).

On the other hand, many of the routinely adopted practices in the maternity hospitals were classified in Group B as: hair removal, enema, fasting, putting routine serum or keeping the parturient lying during the labor process. Finally, cesarean section and episiotomy, for example, were placed in Group D (Enkin et al. 2000; World Health Organization, 1996).

The international evaluation of health care models shows that countries that maintained the childbirth care model, valuing the nurse-midwives' role *(midwife or nurse-midwife)*, such as the Scandinavian countries, England, Japan, Netherlands, France, Germany, among others, have managed to maintain their maternal and fetal/neonatal morbidity indicators low as well as the interventions rate, like cesarean sections, episiotomies etc. The delivery and birth services in those countries prevails by the respect to the physiology and dignity of the woman and her family. As pregnancy and childbirth are physiological processes, they can receive care at the primary care level. The birth can occur at home, in an ambulatory, in birth centers (known as a Natural Birth Center in the Ministry of Health sphere), and at the hospital. Moreover, in the previously mentioned countries, uncomplicated births are attended by a nurse-midwife who conquers the leadership and the recognition of families by knowing the intimacy of most families and by playing an important role in crucial moments of life - such as labor and birth. Besides, the nurse-midwife becomes a reference for the families she attended, a linkage that is recommended by the National Humanization Policy in Brazil. The option for that professional for birth

eutocic care is endorsed by a recent publication of the Cochrane Collaboration (Hatem et al., 2008).

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, work process, management system, social control, subjectivities of caregivers and of care receivers, among other relevant aspects. The proposal/ethical-aesthetic-political bet is a society project based on equity, where access to health services with humanization and quality reflects the assurance of citizenship in a democratic society.

Final considerations

The stabilization of the maternal mortality coefficients is certainly associated with inadequate quality of care, prevailing the deficiency in the component of the care process. One aspect of that component is the interpersonal relationship, which is strongly associated with humanization.

This study has identified a strong international movement that tackles childbirth and labor care humanization as a response both to mechanization in the professional work organization and to institutional violence, with increasing academic production. However, humanization is a polysemic expression and when one comes across to that term it is necessary to identify which perspective is being adopted as well as what meaning is being conferred to it.

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Translated by Maria Aparecida Gazotti Vallim
Translation from **Interface - Comunicação, Saúde, Educação**, Botucatu, v.13, supl. 1, p. 595 - 602, 2009.