LABOR AND BIRTH: KNOWLEDGE AND HUMANIZED PRACTICES

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ABSTRACT: This study aimed at describing the concepts established by health care professionals working in labor and delivery regarding the humanization of childbirth, identifying knowledge and practices of labor and birth humanization, and evaluating the implementation of knowledge and practices in labor and delivery and their relationship with humanization. This is a qualitative descriptive-exploratory research, which was completed at the of Antônio Pedro University Maternity Hospital. The subjects were sixteen health care professionals, including obstetricians and obstetric nurses. Data were collected through semi-structured interviews and analyzed utilizing the content analysis method. It was concluded that professionals are knowledgeable regarding the health policies that provide for the humanization of labor and delivery, follow these precepts and their professional practice is consistent with what is recommended by the policies. These results, however, diverge from results observed in previous studies.

DESCRIPTORS: Humanization of assistance. Humanized delivery. Woman's health.

PARTO E NASCIMENTO: SABERES E PRÁTICAS HUMANIZADAS

RESUMO: Este estudo teve como objetivos descrever os conceitos instituídos pelos profissionais de saúde que atuam na atenção ao parto e nascimento sobre a humanização do parto, identificar saberes e práticas da humanização do parto e nascimento, e avaliar a implementação dos saberes e práticas na assistência ao parto e nascimento e sua relação com a humanização. Trata-se de uma pesquisa qualitativa do tipo descritivo-exploratória realizada na Maternidade do Hospital Universitário Antônio Pedro, cujos sujeitos foram dezesseis profissionais de saúde, entre médicos obstetras e enfermeiros obstetras. Os dados foram obtidos através de entrevista semiestruturada e analisados pelo método da análise de conteúdo. Concluiu-se que os profissionais detêm conhecimentos acerca das políticas de saúde que dispõem sobre a humanização do parto e nascimento, seguem estes preceitos, e sua prática profissional vai ao encontro do que é preconizado pelas políticas. Estes resultados, no entanto, divergem de resultados observados em estudos anteriores.

DESCRITORES: Humanização da assistência. Parto humanizado. Saúde da mulher.

PARTO Y NACIMIENTO: SABERES Y PRÁTICAS HUMANIZADAS

RESUMEN: Este estudio tuvo como objetivos: describir los conceptos instituidos por profesionales de salud que trabajan en la atención del parto humanizado; identificar el conocimiento y las prácticas de humanización del parto; evaluar la aplicación de conocimientos y prácticas en la asistencia al parto y su relación con la humanización. Es una investigación cualitativa de tipo descriptivo-exploratoria realizada en la Maternidad del Hospital Universitario Antônio Pedro, Niterói, Brasil, cuyos participantes fueron dieciséis profesionales de salud, entre médicos obstetras y enfermeras obstétricas. Los datos fueron obtenidos a través de entrevistas semi-estructuradas y analizados por el método de análisis de contenido. Se concluyó que: los profesionales conocen las políticas de salud relacionadas a la humanización del parto y siguen las directrices de estas políticas. Sin embargo, estos resultados divergen de otros observados en estudios anteriores.

DESCRIPTORES: Humanización de la atención. Parto humanizado. Salud de las mujeres.

INTRODUCTION

The humanization of health care appears as an option to modify the existing scenario in the Unified Health System (SUS), which requires changes in the various stages that comprise it, including addressing the difficulties in accessing care and the lack of quality in health services. Humanization means providing quality care to the population, coupling technology with sheltering and also being concerned about the working conditions of the professionals.[1] These needs resulted in the 2004 National Policy of Humanization of Care and Management in the Unified Health System (HumanizaSus), an initiative which operates throughout the system network.

The scenario is no different with regards to the attention given to women's health, especially when considering the quality of obstetric care based on the humanization of labor and birth. Emphasis should be given to the care offered through the Humanization Program during Prenatal and Childbirth (PHPN), which emerged in 2000 with the purpose of encouraging a full obstetric service and guaranteeing the rights of women's choice, aiming further at reorganizing assistance, grounded on the expansion of women's access to quality care and childbirth accomplished with a minimum of interventions.[2] In addition, the PHPN brought the focus of the questions to women and opened up the possibility of much-needed discussions regarding changes in the behavior occurring in the puerperal - pregnancy cycle.

The history of labor and birth is one of transformation throughout history. Since the time of midwife deliveries, a lot has changed with the development and incorporation of new technologies in the field of medicine.[4] Thus, childbirth acquired a new meaning and began to be considered as a surgical procedure, which must be performed by physicians within a hospital setting. This is because "the pregnant woman is considered ill [...] doctors have opposed the intervention of midwives, claiming pregnancy to be a disease that requires treatment from a real doctor ".[5:17-18]

Some health care professionals are critical of the process of humanizing labor and delivery. The training of obstetricians, however, has proved insufficient in order for these professionals to become skilled at providing comprehensive and humanized quality health care, since they are more inclined to use interventionist practices. On the other hand, the training of obstetric nurses aims at a more humanized nature and is focused on the physiology of labor.

It is true that both doctors and obstetric nurses are trained and licensed to assist in low-risk deliveries. However, because their training focuses more on the complications of pregnancy and childbirth, medical professionals tend to perceive childbirth as a high-risk situation, with a need to make use of various technologies. These findings do not exclude the obstetrician in the process of humanization of care, but point to the need for them to modify their practice when assisting in low-risk births, working more effectively as caregivers than 'specialists' in obstetric pathology.[5]

Maternal and neonatal mortality reflect important indicators of quality of care in pregnancy and childbirth, as well as newborn care.[6] In 2002, the maternal mortality rate, obtained from deaths reported, was approximately 53.4 maternal deaths per 100,000 live births (SIM/SINASC). Using the correction factor of 1.4, the maternal mortality rate rises to 74.5 maternal deaths per 100,000 live births, while in developed countries mortality rates reach corrected values from 6 to 20 deaths per 100,000 live births. In the case of children, for every 1,000 live births, 18.3 die within the first 28 days of life.[1]

The National Pact for the Reduction of Maternal and Neonatal Mortality was proposed in 2004 by the Ministry of Health,[6] with the main objective to reduce these rates. It is evident that caesarean sections without adequate indication contribute to increased maternal and infant morbidity and goes against the principles of humanized care of women and newborns. Its use should therefore be restricted to established clinical criteria, but Brazil is still one of the champions of their high rates of operative delivery, which requires an urgent change in mindset. Only then will the childbirth experience revert back to the woman, to whom it actually belongs.

The objectives here, therefore, are to describe the concepts established by health care professionals who work in labor and delivery regarding humanization of childbirth, identify knowledge and practices of labor and birth humanization, and evaluate the implementation of knowledge and practices in labor and birthing care and its relationship to humanization.

This study presents as its main contribution the confrontation of the prevailing discourse in health programs regarding practices established by the professional in the performance of his/her profession. This strategy will enable the analysis of the reflection on the issue of humanization of labor and delivery guided by public health policy. The purpose is to determine whether the professionals involved in the process achieve their target with the benefits recommended in the program or if they are limited only to theoretical discourse.

METHODOLOGY

This is a qualitative descriptive-exploratory study, conducted from February to July 2010 at the Antônio Pedro University Maternity Hospital - Teaching Hospital of Universidade Federal Fluminense, located in Niterói, Rio de Janeiro. The subjects of this study were sixteen health care professionals - obstetricians and obstetric nurses – who worked in labor and delivery.

Data were obtained through semi-structured interviews, conducted in the workplace of the subjects following a pre-established outline. The focus was the identification of the practices of care in labor and delivery. The study was guided by the following issues: how the participant understood the concept of humanization in labor and delivery, which practices were considered by him/her as humanizing and how he used them in his/her day- to- day work. The interviews were recorded to ensure the accuracy of the material obtained.

The project was submitted to the Ethics Committee in Research of Antônio Pedro University Hospital, Universidade Federal Fluminense, and was approved under protocol number CAAE 0129.0.258.000-09. All participants signed the Term of Consent, assuring them anonymity and confidentiality of information, in addition to the right of freedom to withdraw from the study at any given time with no consequences.

After data collection, interviews were analyzed based on the method of content analysis, using the thematic analysis technique, which separates the text into meaning units.[7] Operationally, the thematic analysis was divided into three stages, described below:

Pre-analysis - after data collection, interviews were listened to, on average, two or three times so that it was possible to transcribe them in full. Next, choosing the documents to be analyzed was carried out, allowing the resumption of the research objectives. Finally, indicators were developed which guided the final interpretation of the material under analysis.

Exploration of the material - in this step the meaning was extrapolated. First, recorded units were excerpted from the texts: a word, a phrase, or an event. Afterwards, these units were quantified through indexes and the data were then classified, aggregating them into theoretical or empirical categories that commanded the specification of the theme. Some recorded units found in this study were: women's autonomy, respect for women and couples, respect for female physiology, the professional as a facilitator of the process of humanized labor and delivery and the importance of understanding facilitating processes for practice. These units were then grouped according to their meanings, giving rise to two meaning categories: Care and childbirth from the perspective of autonomy and respect for female physiology, and the health professional as a facilitator of the process of parturition.

Treatment of results obtained and interpreted - Finally, these meaning units were analyzed according to the literature referenced in this research.

RESULTS AND DISCUSSION

Characterization of the subjects

We interviewed 16 professionals, nurses and doctors, equally distributed in the group of subjects. These professionals presented a predominantly female profile, aged between 26 and 55 years, with a dominant title or specialization in obstetrics. The most frequent monthly income was the equivalent of 10 to 20 minimum wages, with an average of 12 minimum wages, salaries received by professionals working in more than one institution, plus their respective titles – with higher salaries for holders of master's and PhD degrees. By tracing the profile of the health professionals in question, it was observed that they have had great difficulty in accessing existing knowledge, without which they cannot stay up-to-date with current knowledge, as can be seen in the chart below.

Chart 1 - Profile of nurses and doctors working in labor and delivery at the Maternity Unit of the Antônio Pedro University Hospital, Niterói, RJ, 2010 (n=16)

Items analyzed	Results found
Time elapsed since graduation	Over 10 years (average 18.1 years)
Weekly workload	Greater than that stipulated in work contracts (average 43.7 hours/week)
Working in more than one institution	Positive for approximately half of the sample
Refresher courses/training regarding the theme of humanization in labor and delivery	Never offered by institution (s) in the workplace.

Source: Malheiros PA.[8]

Assistance during labor and delivery from the perspective of female autonomy and physiology

Female autonomy emerged from the interviewees' speech in the context of the concept of humanization in labor and childbirth. The concept of autonomy is wide and encompasses social, ethical and political approaches, which we do not intend to discuss at this time. Etymologically, autonomy is expressed through the words *auto* = self, *nomos* = rule, regulation, law. Its linguistic origin, therefore, highlights the idea of freedom of choice and the right of active exercise of the self.[9] Autonomy appears in the speech of subjects linked to empowerment, the latter being a consequence of the former. We reproduce some statements regarding this issue below: *They aim at respecting the women's autonomy, providing conditions for women's empowerment* (E2)*; unconditional respect for beliefs, values and knowledge of the woman/couple during the pregnancy and the promotion of autonomy and power of the pregnant woman in labor and in caring for the NB* [newborn] (E6); *recognition of female knowledge, her capacity to gestate and give birth, accepting the woman's role. Making all of the practices, routines and technologies available to this woman (E9) in practice; respect for the woman in labor as to freedom to choose her actions and desires, excluding ineffective protocols and valuing woman as a conductress of birth (E14).*

Empowering is related to the exercise of control over our actions, from access to information to the consequent full awareness of our rights. This is what promotes the change of attitude from passive to active participant, at which point the individual is capable of knowing what is best for himself/herself.[10-11] The subjects in this study cited in various ways the importance of autonomy and empowerment - either through their own words or through the description of their meaning, showing that they value the mother's role in the parturition process.

In the proposal for its creation, the Network for the Humanization of Labor and Delivery (ReHuNa) includes five main goals. One is to encourage women to increase their autonomy and decision-making power over their bodies and parturition.[11] These objectives have been achieved through the progressive participation of women, improving the quality of service rendered during labor and delivery. It is therefore believed that autonomy as detrmined in this study goes through a process in which the woman gradually acquires power to make her own decisions.

To define the humanization of labor and birth, respondents cited autonomy and respect towards women and their inherent physiology, which occurs through the perceptions that professionals have regarding the needs of the women during the pregnancy and childbirth cycle, birth being understood here as a natural physiological event and, for that very reason, deserves care based on non-interventionist models. This idea can be seen in the following statements: *knowing how to care, listen, and observe the physiological process of labor and birth, as well as respect for maternal decisions* (E13) *it is a model of care based on strongly non-interventionist principles that respect female physiology* (E2); *respect for aspects of physiology, unnecessary interventions* (E15).

Throughout the study, the professionals demonstrated their knowledge of the scientific evidence contained in the classification that the World Health Organization (WHO) established in 1996. At that time, WHO outlined the conduct and practices inherent to normal childbirth in four categories, in accordance with their use, ef-

fectiveness and harmful effects, or their absence of these qualities, for the purpose of guiding the conduct of health agents. The statements have shown that doctors and nurses know these principles: *all* [humanizing practices] *respecting bioethics, translated into practice by care based on scientific evidence* (E9); *provide welcoming, respectful, ethical, non-judgmental and safe care based on scientific principles that value women as a process player* (E8); *some of the techniques are no longer recommended* (by the Ministry of Health and WHO], *such as shaving and enemas* (E15); *they are practices considered ineffective, without scientific evidence of their use, and that should be abolished* (E8).

Urged to highlight the humanization techniques that were used in women without dystocia, both types of professionals have proven their assimilation of WHO's recommendations, so much so that the attitude adopted by them led to the reduction of ineffective practices such as giving an enema in labor and the practice of shaving. Results were obtained from procedures, such as the encouragement of vertical positioning that meet physiological needs and contribute to the practice of female autonomy and empowerment. On the other hand, the same professionals differed with regard to the practice of routine episiotomy: *routine episiotomy, yes* (E12), *episiotomy does not need to be performed in all patients* (E7); *routine episiotomy: assault on the woman's genital integrity producing a downgrading/distrust in medicine, a procedure that is not based on scientific evidence* (E16).

The routine use of oxytocin, Kristeller's maneuver or similar maneuvers, enemas, enteroclysis or shaving is no longer used by these professionals, as noted in the statements below: [...] *do not shave the pubic hair [...]* (E16); *in normal birth, shaving does not alter the percentage of postpartum infection* (E7); *oxytocin should only be prescribed if there are changes in uterine contractions* (E7); *oxytocin is way of expediting industrialized delivery and initiating cascade of interferences [...]* (E16); *Kristeller's maneuver*: *downgrading, discredit to medicine based on no scientific evidence* (E16); *no need of an enema, because if the patient evacuates their bowels, it is easier to maintain asepsis if the stools are solid rather than liquid* (E7); *not to mention enema and provide comfort and discretion when the woman has a bowel movement* (E16).

The survey collected other data that have benefits for the service and its users. Respondents cited the delivery and childbirth humanizing techniques that they use, including non-invasive and non-pharmacological pain relief methods. They also see the woman as the central character of birth and encourage early and intimate skin contact between mother and child. Other humanizing procedures cited were free dietary discretion and respect for the woman's choice of her companion: [...] *freedom to eat and drink fruit/juices/soft foods during labor* (E16); *having a companion of her choice throughout labor* (E11); *to welcome newborns, promoting the introduction of mother and child as early as possible* (E11).

It is worth highlighting that the professionals who restrict food before and during labor, considering that during the parturition process there is significantly higher energy expenditure and the woman should be fed,[12] justify their action by stating the risk of aspiration of gastric content in case anesthetic is required. However, evidence shows that higher levels of aspiration are associated with the use of general anesthesia in childbirth, which today occurs infrequently.

As mentioned, another important issue pointed out by respondents was the contact of the newborn with the mother, the aim of which is to intensify the bond between mother and child as early as possible. It is worth remembering that the moment of birth is the richest for the formation of the mother-child bond; therefore, care for the newborn should be restricted to what is strictly necessary so that this contact can be established as early as in the delivery room, contributing to the creation of a strong attachment.[13]

Participants reported receiving feedback regarding physical and emotional well-being from the woman, promoting activities that relieve pain and provide comfort (such as walking), encouraging freedom of position and movement during labor, and encouraging vertical (upright) postures. However, they also confirmed the performance of delivery in the lithotomy position: *delivery in a lithotomy position: likely to be comfortable for the woman, as long as the FCB [fetal heart beats] are stable and labor is physiologically progressing. If imposed: ignorance, lack of qualification, abuse of power, shows priority of comfort for the health professional at the expense of woman's comfort* (E16); *I observe, encourage and support the various positions of women in labor* (E2); *I guide the women as to walking and/or offer new positions* (E14); *I use massage, cold/hot compresses, warm baths, distraction, comfort techniques, relaxation techniques; that is, several non-invasive care techniques* (E2).

A study conducted with 35 mothers identified that over half of the participants consider that movement and walking are beneficial during labor, because these activities provide pain relief, enabling them to have a shower or bath to accelerate labor.[14]

In addition, research conducted in a municipal maternity ward of Rio de Janeiro between 2004 and 2008 revealed high rates of the use of non-pharmacological obstetrical practices (85.3%), characterized by walking, pelvic movements and breathing exercises. It also identified that 60.6% of births occurred in the presence of a companion, in a predominantly vertical position (77.6%) and 30.2% of these women did not experience any perineal injury.[15]

The respondents mentioned the issue of female autonomy as central to the process of humanization of labor and childbirth, stressing the importance of non-intervention and respect for female physiology. They state that they adopt techniques that demonstrate adherence to scientific principles to promote the humanization of the process using the justification that the woman - by assuming an active posture during labor and delivery - acquires empowerment and decision-making ability.

The health professional as a facilitator of the delivery process

A thorough discussion regarding the reformulation of the model of care delivery provided during childbirth is necessary to reduce the interventionist nature that this process once entailed. The debate should be based on scientific evidence, seeking to enhance the concepts and practices for monitoring and providing counseling during childbirth.[11]

In order for this facilitation to be observed with certainty, it is necessary to identify the risks inherent in delivery for each pregnant woman. The responding professionals, however, showed superficiality when the theme addressed was the need for an actual intervention to classify the risk, which means that although they emphasize the importance of the professional as a facilitator of the process of parturition, they have not advanced to a classification of risk that sustains their own role as a facilitator.

"The concept of risk is associated with that of probabilities, and the linkage between a risk factor and subsequent damage is not always spelled out".[16:22] Classification during the prenatal period of routine, average or high risk delivery is paramount, although there are still doubts regarding the systems used.[10] In this regard, classification allows for medical interventions to be applied correctly, ensuring the safety of both the mother and baby, reducing risks derived both from non-availability of interventions that are necessary and iatrogenic uses in cases of routine risk.

Among the professionals surveyed the following statements emerged: [...] *support and respect the mothers' decisions in cases of low-risk delivery [...]* (E13); […] *support for the mother, only intervening in cases of real need* (E2); *there should be a consideration that labor and birth is a physiological process that has a risk of complications, but the professional must be technically able to offer quality, safe care [...]* (E8).

The best way to offer a more adequate level of care in this context would be to add systematized and confirmed scientific and technical knowledge to humanized practices of labor childbirth.[11,17] This will ensure that, according to their own statements, the professional has sufficient knowledge to observe the parturition process patiently. The doctor and nurse should know exactly when a complication occurs or when one is imminent, and act in accordance with the recommendations of the Ministry of Health.[5] According to this government agency, the role of the caregiver is to observe for the possibility of a deviation in the pathological direction where one can, with trust and care, use the art and technology available to save mothers and babies. These aspects are well illustrated in the following lines: [...] *patience to let the process flow naturally without generating concerns that generate interventions* (E6); *try not to intervene in the natural process of birth* [...] *respect the wishes of the mother and her time* (E13).

Care considered to be most effective would involve placing the mother as the central figure in the labor 'event', valuing her needs over the demands of professionals and/or institutions.[18] Thus, each woman should be characterized as unique, the owner of her own needs with the means to provide for them, and the professional should be scientifically prepared and trained; that is, qualified to assist her within the humanization philosophy. The statements that follow regarding humanizing practices illustrate the opinion of the subjects on how each woman has her own wishes which the professional must adapt to: *we must remember that there is no list of practices that should be considered essentially*

humanizing. There are women who like to be alone, others refuse massages, incense sometimes makes them queasy (E3); *it is a huge and creative set that changes with each delivery/birth* (E16).

When asked about the role of health professionals in the humanization of the labor/birth process, the study subjects assigned themselves the role of facilitators of the delivery process. In a way, they put themselves in the process as spectators outside the physiological act; thus, they reduce the number of interventions as much as possible and ensure the right of the woman's choice. They also stressed that the professional should have technical skills and knowledge with a strong scientific base. The latter aspect can be observed in the following statements: [...] *guarantee the right of the women to make choices, besides being a mere spectator* [...] (E2), *put oneself above all as a facilitator of the process* (E10); *reduce unnecessary interventions and foster care based on an understanding of what is physiological and natural* (E11).

The study participants reported several obstacles to the practice of humanization in labor and birth. One of them is the resistance of some health professionals who cannot accept the process, without which it is not possible to break with the current paradigm. They also highlighted their training based on the biomedical model and the consequent lack of preparation of the teams. It appears, therefore, that investment is needed to update the knowledge, development and training of health workers, aiming not only to deconstruct the model learned, but also to transform their knowledge into a pattern of humanized childbirth and newborn service.[13] Some statements collected speak for themselves: [...] *the main difficulty is, of course, the resistance of other professionals. The clash between the models of care often leads to problems with the staff and with the institutional authorities* (E2); *physicians who do not share our view make it difficult to change these routines. Healthcare professionals involved with childbirth have not attended lectures and courses to update their knowledge and deconstruct the old model that they have learned* (E13); *the greatest difficulties are the inability of professionals to divest themselves of their pride and at the same time become more sensitive to changes of paradigm* (E10); *The difficulty of most of the professionals in accepting such practices, due to the learning they received, is a factor that contributes negatively to changes of paradigms, which considers labor and delivery as a pathological process and not as a physiological process* (E8).

Research performed in public hospitals in São Paulo in order to compare women's satisfaction with the birth experience under different models of care concluded that the peri-hospital model was rated best and was related with the highest degrees of satisfaction.[19] This demonstrates the important role of the health care professional in the meaning of the labor experience for the woman and her social network.

It is necessary to break with institutionalized childbirth, a practice which many professionals have become used to, performing techniques without proven benefits according to scientific evidence as a result of their academic education.[17]

The participants stressed the importance of the professional as a facilitator of the parturition process, supporting the argument that the humanization movement should counteract the biomedical model to rescue the experience of women during the process of pregnancy and childbirth, provided that health workers adopt a behavior of risk stratification. They recognized, however, the importance of technological resources when the use of these tools is necessary and properly applied. They admitted that professionals must necessarily have the scientific knowledge to support their practices, and that the update of such knowledge must be permanent and ongoing, especially since scientific advances evolve rapidly and promote constant changes, both in knowledge and in the process of academic learning.

CONCLUSION

It was clear that the professionals interviewed have knowledge of health policies that address the humanization of labor and childbirth, as evidenced by their declaration that they put into practice the precepts dictated by institutional organizations sympathetic to the theme and apply these concepts in solving issues they are faced with daily, including autonomy, physiology, expectant conduct and risk classification. Health workers claimed that they adhere to the mandates of what is recommended by health policies, but stressed that there is a discrepancy between what they say and statistics, and what the study project highlights. Often, professionals portray ignorance when they outline their knowledge and practices. It is common to find health care providers who admit to using techniques not recommended by the World Health Organization and that are also contrary to the stipulations of the Ministry of Health to humanize labor and birth.

The decisions of the woman throughout her delivery process are essential so that the birth will be humanized and natural. This will happen when professionals understand that this process does not only address scientific evidence, but should also take into account the risk classification, without which it is difficult to determine the correct time for intervention.

Regarding the implementation of humanization in labor and birth, it was observed that some of the professionals recognize the need for a change in paradigm, the search for new knowledge and a change in the ways of training doctors and nurses. Nevertheless, this qualitative leap will only happen through the deconstruction of the technocratic model and the subsequent acceptance of the humanistic model.

We believe this is an important means for the health professional to become a facilitator of the parturition process, respecting the physiology of childbirth, the principle of non-intervention and respect for female autonomy.

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