

MOTHERS' HEALTH IN BRAZIL AND RECOVERING THE TRAINING OF MIDWIVES FOR CARE IN THE BIRTH PROCESS

Miriam Aparecida Barbosa Merighi¹

Dulce Maria Rosa Gualda²

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The authors briefly analyze the situation of maternal health care in Brazil and, based on their findings, they comment that there have been transformations in the health care model for women and families and propose some measures, including recovery of the work of the obstetric nurse or midwife (obstetriz, in Portuguese). They comment that women care tendencies in the delivery process presuppose incorporation of the paradigm of improving the physiology of valuing women's experience, the approach to the family, health advice that prioritizes prevention, education and relationships, without ignoring safety. They appoint that building this health care model, which includes the work of the midwife, may improve maternal health indicators.

DESCRIPTORS: obstetrical nursing; midwives; delivery of health care

EL CUIDADO DE LA SALUD MATERNA EN BRASIL Y EL RESCATE DE LA ENSEÑANZA DE OBSTETRAS PARA ASISTENCIA AL PARTO

Los autores hacen un breve análisis de la situación del cuidado de la salud materna en Brasil, y con base en sus hallazgos, sugieren transformar el modelo de atención a la mujer y a sus familiares; proponen algunas medidas que incluyen la inserción del trabajo de la enfermera obstétrica y de la obstetra en el contexto actual. Comentan sobre la tendencia actual del cuidado materno en el proceso del nacimiento, el cual presupone la incorporación del paradigma que favorece la fisiología y la valorización de la experiencia femenina, el abordaje centrado en la familia con énfasis en la prevención, educación y relación interpersonal sin dejar de lado la seguridad. Consideran que el modelo del cuidado de la salud que incluye el trabajo de la obstetra, puede mejorar los indicadores de salud materna.

DESCRIPTORES: enfermería obstétrica; matrona; prestación de atención de salud

O CUIDADO A SAÚDE MATERNA NO BRASIL E O RESGATE DO ENSINO DE OBSTETRIZES PARA ASSISTÊNCIA AO PARTO

Os autores fazem uma breve análise da situação do cuidado a saúde materna no Brasil, e com base nesses dados, apontam as transformações no modelo de assistência à mulher e às famílias e propõem algumas medidas, as quais inclui a inserção do trabalho da enfermeira obstétrica ou obstetriz no contexto atual. Comentam que a tendência atual do processo de nascimento pressupõe a incorporação do paradigma que favorece a fisiologia e a valorização da experiência feminina, a abordagem centrada na família, com ênfase na prevenção, educação e relacionamento interpessoal, sem deixar de lado a segurança. Consideram que o modelo de cuidado à saúde, que inclui o trabalho da obstetriz, pode melhorar os indicadores de saúde materna.

DESCRIPTORES: enfermagem obstétrica; obstetriz; assistência a saúde

INTRODUCTION

In Brazil, health indicators related to obstetrical care are discouraging. A chain of events causes their occurrence, for which responsibility can be attributed to the population's sociocultural and economic characteristics, policies, inequality and social exclusion. Maternal mortality rates are very high. The excessive use of cesarean sections pictures the situation that has contributed to the dehumanization of care, and the preparation and activities of the obstetrical team in care has been the subject of intense debates. In view of this situation, this text aims to report data about maternal health, appoint trends in women's health care during the reproductive period and contextualize the creation of a course that favors a new birth care model. These aspects are discussed in further detail below.

Status of maternal health in Brazil

An analysis of the status of maternal health care in Brazil shows the serious epidemiological situation lived by women and their neonates and the precariousness of health care provided to the population.

The policies that have been adopted, management problems, reduced funds and personnel, the lack of material and medication have led to the breakdown of health care. Pre-natal care, when available, is inadequate. There is no assurance of a place in hospital at the time of delivery. At delivery, technology, depersonalized and interventionist medical practice are given a special position, and there are high rates of cesarean sections and alarming rates of maternal mortality⁽¹⁾.

Maternal mortality is the indicator that best reflects the conditions of maternal care during the pregnancy-puerperal period, since a timely and adequate intervention could avoid most of these deaths⁽²⁾.

Data from 1997 show that, in Brazil, 110 mothers die for every 100,000 live births, which is similar to some of the poorest countries in Latin America⁽²⁾.

The maternal death coefficient also shows social inequality and exclusion in Brazil. The data shows the inequity and reality of each region. The most underprivileged regions of the country display the highest female mortality numbers for maternal

deaths. The worst figures are found in the North, followed by the Central-West and Northeast, which are the neediest regions. The South and Southeast regions, which are more developed, show the best figures⁽³⁾.

The main causes of maternal deaths are: hypertension, hemorrhage, abortion complications and puerperal infections, which we considered direct causes and closely related to socioeconomic factors, responsible for 89% of maternal deaths⁽⁴⁾.

A chain of events is involved. These include: social, cultural and economic characteristics of the population; pathologies specific to pregnancy; fragmented structure of the health system, where each person provides care in isolation; inefficiency of the referral and counter-referral system; lack or poor distribution of hospital beds for delivery in the regions, which overloads many institutions; abusive use of technology and obstetric interventions, which increase morbidity; quality of prenatal services, which is the bottle-neck of health care⁽⁵⁾.

For health care workers, low salaries lead to and justify their lack of commitment and the commercialization of health. Other factors are shortcomings in training and work conditions, which lead to unnecessary bureaucracy in health care; the lack of humane care in health, where priority is given to mass treatment routines instead of care for individual needs; ignorance of women's health-disease stories and gradual substitution of clinical work by new technologies.

In general, there are distortions in the very concept of delivery care in Brazil, as a result of the adopted paradigm, which influences the way care is given and, consequently, its quality, interfering in both procedures and interpersonal relations. The issue of the indiscriminate use of interventions has been dealt with from different points of view, and the biomedical model has been mentioned as the great villain. In this context, it shows itself as a cause of the number of cesarean sections in Brazil, which figures among the highest rates in the world. In the last four years, the state of São Paulo has had an average of 50.3% deliveries by cesarean section, while the average for the country as a whole is 40.5%⁽⁴⁾.

Status of education

An analysis of maternal health care in Brazil shows a crisis situation, with no less education problems.

There is a breakdown of education at all levels, which includes the training of health workers. The education of these workers is not an isolated process, but is related to the economic and social structure and establishes relations with various other processes that are more closely linked to the fields of practice⁽¹⁾.

Most of the curricula of colleges that train workers are bio-centered, and the educational process emphasizes disease, technical procedures and technology. Also, the environment practical teaching takes place in does not allow for humanitarian practice.

The need to reformulate the way health workers are trained is known because of the current crisis in the health sphere, both in quantitative and qualitative terms.

The health-disease process involves the complexity and uniqueness of human life and requires a new outlook on health worker training. Therefore, the current tendency in education should be based on the socio-centered model.

On the other hand, training health workers should follow a path in which this space of learning can use art to bring about changes in health care, in order to train people who are sensitive and able to understand the dimension of humane care⁽¹⁾.

With regard to delivery, the challenge is to understand, recover and reveal the process as unique, humanized and moving away from depersonalization and interventionist actions⁽⁶⁾.

Tendency of women's health care during delivery

The tendency of women's health care during delivery presupposes the valuation of women's experience, approach of the family as the basic social nucleus and health guidance. This can be done both in and out of the hospital context, always prioritizing preventive, educational and relational aspects of the process, without ignoring safety.

Obstetric nurses and midwives (*obstetrizes*, in Portuguese) are trained in these aspects and good health care results can be seen at national and international levels⁽⁷⁾.

Sheila Kitzenger underlines the importance of midwives throughout history in several health systems. Researching their practice, she acknowledges that, in most systems, they have practically disappeared. In some places, she says, they only follow doctors' orders. In others, their activity is fragmented and directed at the procedure and not

at the women themselves. However, in places where they work with autonomy, they have attained very satisfactory results and carried out an important role in bringing about change, examining universally accepted obstetric practices. She states that midwives carried out the research on routine shaving of the perineum, enema and episiotomy, noting that these practices are not always beneficial and cause extreme discomfort to the mothers. She also says that studies in the United Kingdom and the United States have shown that deliveries by midwives have lower rates of cesarean section, forceps, induced birth and electronic control of focus and that medication is used with less intensity. The babies have a high Apgar score, and are rarely intubated⁽⁸⁾.

Given these facts, we believe the responsibility for care at normal delivery can be transferred to the midwives, who receive training that is better suited to monitor delivery and let physiology work, calling on physicians only in cases in which there is a risk.

The World Health Organization (WHO) agrees and considers that, through less intervention, midwives and obstetric nurses are the most appropriate workers to assist normal pregnancies and deliveries (WHO, 1996). This approach influences the profession through many health worker training courses in normal delivery. This includes the existing specialization courses for obstetric nurses, after they conclude their nursing degree, as well as graduate studies to train midwives. These considerations gave rise to a discussion on a possible return to midwifery training at undergraduate level, parallel to the specialization in obstetric nursing. This discussion has started in regular seminars and, internally, in the obstetric nursing course offered at the Mother-Child and Psychiatric Department of the University of São Paulo School of Nursing.

Students graduating from these courses should have the profile and competence to monitor the physiological process of delivery, contributing to its natural evolution, recognizing and correcting deviations from normality and forwarding those that need specialized care. They should also have the role of facilitating the woman's role in delivery, moving toward the model based on the principles of humanization. This, as we understand it, is based on respect for human beings, empathy, inter-subjectivity, involvement, bonding, allowing women and their families the possibility of choice according to their cultural beliefs and values.

Humanization of health care also involves learning different concepts, values and cultural practices that exist in our midst, associated to delivery and birth (half-castes, indigenous, rural, urban, etc.). Greater access to information on different habits and customs associated to birth allows for a more flexible and tolerant attitude towards differences, with more effective communication between health workers and patients, seeking to meet the needs of mothers and families.

Hospitalization has been mentioned as a real obstacle for the humanization of delivery care. Therefore, it has been suggested that normal delivery centers be set up for low risk cases. This is because they are small care centers, with less bureaucracy and lower risk of infection than large maternities. The normal delivery centers can be inside or outside a hospital structure. When outside, they should be located near a hospital, with available transport in case of complications. Obstetric nurses and midwives would be the main people responsible for eutocic delivery.

Another aspect to be considered is the substitution of obsolete practices by scientific evidence on which to base obstetric practice. Although some are already well documented, delivery health workers still display a lack of interest and knowledge on this evidence. An example of this is the excessive use of cesarean section by physicians, which has led to the de-humanization of health care, as well as increased mortality and morbidity for mothers in the perinatal period, besides waste of the health sector's scarce resources.

Recovering the role of midwives in delivery care in Brazil

Government agents have acknowledged the model of health care for women and families in the reproductive process as necessary. It has become the subject matter of national health policies. Some measures taken can be listed, such as the Program for Humanization in Prenatal Care and Delivery, the setting up of normal delivery centers and the funding of specialization courses in obstetric nursing provided by nursing schools throughout the country.

For health care delivery to women during pregnancy and the puerperal period, the World Health Organization (WHO) and the Brazilian Ministry of Health recommend greater participation of obstetric nurses and midwives because of the importance of assisting delivery, improved care in normal delivery and

reduction in the number of cesarean sections. As a preventive measure, in 1998, the Brazilian national health system (SUS) established remuneration for care in deliveries carried out by obstetric nurses⁽⁹⁾.

Up to 2005, the only course to train health workers in delivery care was through specialization, with the pre-requisite of a nursing degree.

However, because of the situation of reproductive health care and articles in international and national literature, the role of midwives with a university degree began to be discussed. Therefore, in 1998, the Brazilian Association of Midwives and Obstetric Nurses – São Paulo Section, intensified discussions on nursing teaching in delivery and birth care through seminars in the state. The main drawbacks shown in the current model for training in this field are the high investment and excessive time needed to qualify workers. Next, the possibility of training midwives (direct entry) for women's health care was considered from a new point of view. It also takes into account scientific evidence midwives bring to the physiological and natural procedure at delivery, as well as personalized and humane care.

Thus, wide discussion has been ongoing on the training of midwives, given that this is an important resource to provide health care to women during pregnancy, near and after delivery, as well as to the newborns and their families.

Midwifery courses already existed in Brazil. They began to disappear in the early sixties. Care for women during the reproductive period moved to obstetric nurses trained in nursing schools.

Although graduate specialization in nursing obstetrics has been an important strategy for training nurses in this field, this single track was not adequately supplying the demand for workers in the country, neither in terms of figures nor adequate training, given the cost and social returns in teaching, research and health care. The need was felt for a course with a structure and duration that would give midwives a profile and competence that enabled them to participate actively in the necessary transformations in the health care model and the epidemiological situation of maternal and perinatal health.

The proposal of a midwifery undergraduate course by teachers from the Department of Mother-Child and Psychiatric Nursing Course began in 2001. The intention was to establish and develop a form of training and qualification of health workers in tune with local reality, in order to produce the necessary and

expected input for the quality of health of women and their families in the region.

Midwives were thought of as belonging to the health team, capable of working independently, responsible for care delivery during normal pregnancy and delivery. They would be an important resource for health care delivery to pregnant women, women in delivery, neonates and families, and promote and preserve the normality of the birth process, meeting women's physical, emotional and sociocultural needs. On the other hand, these health workers would have the profile and competency to actively participate in transforming the epidemiological health status of mothers and in the perinatal period.

Course creation proposal

In order to meet the social demands, an undergraduate course in midwifery was proposed to the University of São Paulo – East Zone, on the occasion of an expansion by 1,000 places. The new campus was set up as an integrated unit with courses in humanities, arts and sciences that were not available at the University of São Paulo – Capital. The intention was the development of interdisciplinary proposals directed at the reality of society and the region, including new teaching models, research projects and community services.

To reach these objectives, the course was planned based on the basic cycle, in which students have an opportunity to experience three interwoven areas of training:

- Basic knowledge specific to health care;
- General training, made up of subjects that provide humanistic support to later studies;
- Scientific training through problem solving, scientific initiation in which students carry out research projects linked to social issues.

Starting with the basic cycle, the axes are present throughout the remaining six semesters of the course. Each axis consists of curricular subjects, ordered by criteria of content continuity and growing complexity. The Midwifery (Obstetric) course axes are:

- Biological bases of Obstetrics;
- Psycho-social fundamentals of the reproduction process;
- Care delivery in the reproductive process;

Although longitudinal, these axes are interwoven to converge to a practical and research context, through fieldwork with an emphasis on

technical, expressive and interactive skills and problem solving groups, providing a critical analysis of health care activities. This content is therefore addressed in an integrated and gradual way.

The initial number of places was 60 for the evening course, beginning in 2005. The minimum duration of the course was set at a minimum of eight and a maximum of twelve semesters. The profile of graduating students was established as:

- Capable of recognizing the physical, emotional and sociocultural dimensions of people's lives which affect the reproductive process and need care;
- Understand the reproduction phenomenon as unique, continuous and healthy, in which women are the focal point, and which occurs in a given social and historic context;
- Provide normal development of the birth process, providing care and support and assuring the participation of women and their families;
- Develop a health care and education process based on interaction with partnership, allowing the people involved to make their health decisions;
- Make clinical observations, scientific knowledge, technical skills and intuitive judgment a part of decision making;
- Value interdisciplinary knowledge and action;
- Develop attributes based on ethical and political responsibility and professional autonomy, based on principles of equality, respect for self-determination and humane environment.

Competencies and skills

- Provide and coordinate health care for women and their families during the reproductive process;
- Work in public and private health institutions (maternities, normal delivery centers, birth houses, outpatient departments, basic health clinics), teaching institutions and homes;
- Work in multidisciplinary team;
- Work interactively at all levels;
- Contribute to build knowledge in the area and base practice on existing knowledge;
- Train personnel in the specific field.

GENERAL REMARKS

The situation of reproductive health in Brazil presents an epidemiological picture with high maternal

and perinatal mortality rates, indiscriminate use of interventions, which can easily be observed in the high cesarean section rates, reflecting the low quality of obstetrical care.

As to aspects related to professional education in health, data are not very encouraging either. Curricula are biocentered and repetitive. Clinical teaching occurs in an environment that discourages change and does not favor care humanization.

In policies as well as in care humanization proposals, the training of obstetrical nurses or midwives has been valued. To fill this gap, the Obstetrics Course

has been created, based on innovative educational models. The goal is to allow these students to become sensitive professionals who are apt to understand the dimension of humane care and to participate actively in maternal and perinatal health transformations, turning them into important resources in health care delivery to pregnant, parturient and puerperal women, as well as infants and relatives.

Therefore, the authors believe that these professionals can positively affect the unfavorable maternal and perinatal health indicators, which has been the case in different European and North American countries.

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