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Childbirth: From Obstetric Violence to Humanization

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Editorial

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Abbreviations: SUS: Unified Health System; WHO: World Health Organization.

Editorial

For women, the birth of a child can be associated with the renewal of life and represent one of the most intense and significant events in human existence. Therefore, childbirth care should be centered on women's needs, considering their rights and their active participation in the parturition process. In addition, the risk aspects peculiar to each pregnant woman must be highlighted and increased in care in order to preserve the quality of care and comprehensiveness [1]. However, in Brazil and many other countries, these rights, which are preconditions for health and citizenship, have been gradually violated.

Until the end of the 18th century, childbirth was a women's ritual, carried out in family homes and accompanied by midwives. At the end of the 19th century, a process of change began through obstetrics' attempts to control the biological event, so that labor and birth, which had traditionally been understood as physiological and feminine events, began to be seen as a medical and masculine event, including the notion of risk and pathology as the rule, and no longer the exception. In this technocratic model, the woman is no longer the protagonist and the doctor is in charge of the process. From the 20th century onwards, the process of hospitalizing childbirth accelerated and there was an increase in the use of technologies with the aim of initiating, intensifying, regulating and monitoring childbirth, all to make it 'more normal' and obtain health gains for mother and baby.In order to increase the quality of care, childbirth has been medicalized, with large-scale use of procedures considered inappropriate and unnecessary, which can often put the health and lives of the mother and baby at risk, without adequate assessment of their safety and without any evidence base [2]. Characterized by a growing dependence on technical and technological interventions and the widespread use of caesarean surgery as a way of giving birth, the current obstetric care model is marked by the expropriation of control over women's bodies, thus making it impossible for them to exercise their autonomy. In this process, childbirth has come to be experienced as a moment of intense physical and moral suffering.

The World Health Organization (WHO) recommends that the rate of caesarean sections in a country should vary between 10 and 15%, since, according to studies, a rate higher than 15% does not represent a reduction in maternal mortality or better health outcomes for the mother-baby pair. In Brazil, approximately 1.6 million caesarean sections are performed each year, so that caesarean section has become the most common mode of birth in the country. Data released by the Brazilian Ministry of Health shows that the caesarean section rate is 56% in the general population, with these figures varying between the public and private healthcare systems, which have an occurrence of approximately 40% and 85%, respectively [2]. When performed for medical reasons, caesarean sections are effective in reducing maternal and perinatal mortality and, under ideal conditions, caesarean sections are a safe operation with a low frequency of serious complications. However, this operation is often used unnecessarily, without medical reasons that could justify the high rates observed. Thus, operations that occur when there is no situation that puts the health of the pregnant woman or the baby at risk and would therefore require intervention through a procedure are considered unnecessary, as performing surgery without the correct indication can lead to an increased risk of serious complications for the dyad. In addition to its effects on maternal and neonatal morbidity and mortality, caesarean sections can interfere with mother and

baby bonding, breastfeeding and the woman's reproductive future, as well as possible long-term repercussions on the child's health [3].

In addition, one in three pregnant women treated in private hospitals experience violence, and in the Unified Health System (SUS), 45% of women are mistreated during childbirth [4]. Obstetric violence is a complex problem involving issues of gender, power and inequality, and addressing it requires interdisciplinary action and a paradigm shift in maternal health care. According to the World Health Organization (WHO), obstetric violence is classified as occurring when there is verbal abuse, inhibition of the presence of a companion, medical procedures without the need or consent of the pregnant woman, violation of privacy, refusal to administer painkillers, physical and verbal violence, among others. Women all over the world experience or have experienced some kind of abuse, insult, offense, disrespect, inattention and mistreatment during labor in healthcare facilities and these events can have adverse consequences and traumas for the pregnant woman and her baby, especially as this is a very important moment in a woman's life [5].

Research on the subject points to the frequent presence of disrespect towards the parturient woman, and classifies the violence reported into categories: physical abuse, undignified care (such as shouting or threats), non-consensual care, non-confidential care or lack of privacy, negligence, detention in the health establishment and discrimination associated with age, occupation, marital status and educational level. These surveys also report on the negative experiences of parturient women, which include feelings of fear, worry and helplessness, lack of pain relief methods, discomfort at interventions performed, an uncomfortable or inappropriate hospital environment, maternal and neonatal complications, lack of contact with the baby immediately after delivery, limitations on participation in the care of the newborn, disrespect and offenses during delivery, lack of knowledge about labor, unmet needs or preferences, as well as the negative position of health professionals and family members in relation to vaginal delivery [1]. According to the survey "Nascer no Brasil: Inquérito Nacional sobre o parto e nascimento", 73% of the women who took part in the survey did not have access to non-drug pain relief procedures, such as a hot bath; only 26.6% of newborns had contact with their mother's skin immediately after birth and 40.9% of mothers breastfed their baby within the first hour of life [6].

In order to restore female autonomy in childbirth, from the 1980s onwards, the feminist movement, along with other sectors of society, began to strongly criticize this technocratic obstetric model. They mainly questioned the quality of care provided during the pregnancy-puerperium cycle, the institutionalization of childbirth and the routine use of unnecessary interventions. This movement culminated in conferences, documents and the search for scientific evidence to link the various areas of knowledge [7]. In 1993, the Network for the Humanization of Childbirth and Birth (Rehuna) was founded in Brazil. Through the Campinas letter, it denounced the circumstances of violence and embarrassment in which care is provided, and the subhuman conditions to which women and children are subjected during childbirth. In addition, since 1998, the Brazilian Ministry of Health has been training obstetric nurses to assist in normal childbirth, through specialization courses in obstetric nursing and ministerial ordinances to include normal childbirth assisted by obstetric nurses in the SUS payment table [8].

Therefore, in view of the understanding of the impact of gender relations on women's health, health policies have been expanded from the perspective of comprehensive care. In Brazil, a number of public policies have been created to improve the quality of prenatal and childbirth care for women, with a potential impact on reducing obstetric violence: The National Program for the Humanization of Childbirth and Birth (2000), which involves several determinations, such as the right to access and qualitative, ethical and dignified care during pregnancy, childbirth and the puerperium, and establishes guidelines that guarantee the well-being of women and their babies; the Accompanying Person Law (2005), which guarantees parturients the right to an accompanying person during labor, childbirth and the postpartum period; Rede Cegonha - Maternal and Child Care Network (2011), which aims to ensure women's right to reproductive planning and humanized care, as well as children's right to safe birth and healthy growth and development; and the National Guidelines for Pregnant Women's Care (2015/2016) [5].

Humanization encompasses respect for personal values, team integration, offering safe and holistic care, promoting trust and physical and mental comfort, respecting and valuing the human person, offering emotional support, involving the companion or family, among other aspects. Situations of vulnerability for pregnant women need to be approached in a broad way, taking into account the causes, contexts and subjective perceptions of why they find themselves in a certain situation, and that these causes involve different complexities, situations and experiences. Thus, care strategies should be individual, taking into account the woman's reality and preserving her well-being based on her life context and streamlined under ethics, respect and humanization [1].

However, there are many difficulties when it comes to implementing humanized childbirth, such as inadequate

physical infrastructure, such as maternity wards with poor conditions, lack of supplies and overcrowding, which have a direct impact on the care provided. Often, the number of pregnant women exceeds the number of obstetric nurses and nursing technicians, which creates a work overload for these professionals, who thus fail to provide comprehensive care at this complex and special time [9]. In order to achieve this, it is also necessary to provide information to pregnant women during prenatal care, childbirth and the puerperium based on up-to-date, good quality evidence, pointing out the benefits and risks of forms of delivery and birth, including the pregnant woman in the decision-making process. Finally, the health system needs to increase the number of qualified professionals who are personally and professionally committed to welcoming women in a respectful, ethical and dignified manner, and who are encouraged to promote the recovery of women's active role in this process.

References

1. Trevisano RG, Gonzaga MFN, Almeida CGde, Contini ICP, Souza LAde, et al. (2022) Women's frailties in childbirth and the puerperium: an integrative review. Brazilian Journal of Development 8(3): 20637-20655.

2. de Pinho Zanardo GL, Uribe MC, Nadal AHRD, Habigzang LF (2017) Obstetric violence in Brazil: a narrative review. Psicol Soc 29: e155043.

3. (2015) National Commission for the Incorporation of Technologies into the SUS. Care Guidelines for Pregnant Women: cesarean section.

4. Leite T, Marques E, Esteves-Pereira A, Nucci M, Portella Y, et al. (2022) Disrespect and abuse, mistreatment and obstetric violence: a challenge for epidemiology and public health in Brazil. Cien Saude Colet 27(2): 483-491.

5. Santos J, Rosa AG, Oliveira LD, Santos DG, Ferreira SC (2024) Nurses' Perception of Prevention and Impacts Regarding Obstetric Violence. Brazilian Journal of Implantology and Health Sciences 6(4): 2531-2551.

6. (2029) National survey on labor and birth (2011 to 2012). Born in Brazil.

7. dos Reis TLR, de Mello Padoin SM, Pasa Toebe TR, de Paula CC, de Quadros JS (2017) Female autonomy in the labor and birth process: integrative literature review. Rev Gaúcha Enferm 38(1): e64677.

8. de Jesus S Pires Moura FM, Crizostomo CD, Nery IS, de Cássia Magalhães Mendonça R, de Araújo OD, et al. (2007) Humanization and nursing care during normal birth. Brazilian Nursing Magazine 60(4): 452-455.

9. Lima Fernandes F, Albuquerque GS, Lima SM, Silva KNA, Santos RS, et al. (2023) The challenges for implementing humanized birth: an integrative review. Brazilian Journal of Implantology and Health Sciences 5(5): 2955-2965.