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Process of humanization of childbirth: Historical evolution and perspectives

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***Keywords*— Humanized Childbirth, Humanization of Assistance, Obstetrics.**

***Abstract*— *The study aimed to investigate, through the literature, the historical evolution and perspectives of the humanization process of care during childbirth. This is a bibliographic research, in which two databases were searched, namely: SciELO and LILACS, with national publications in the last 10 years. Fourteen scientific articles were analyzed using articles published in Portuguese as inclusion criteria; full articles and articles published and indexed in the aforementioned databases in the period from 2012 to 2022. As a result, it became evident that the humanization of childbirth is very current and still occurs as a reaction to several procedures performed without indication, requiring efforts to all the subjects involved, seeking to guarantee the woman quality and comprehensive care, which requires from all the actors involved with health care efforts to abolish aggressive behavior. It was*

concluded that the movement for the humanization of childbirth shows that the issue of birth is also the responsibility of the government and, given the current problems such as those related to the infrastructure weaknesses of the health network in Brazil, it is also configured as a health issue public.

I. INTRODUCTION

Over time, midwifery has undergone numerous changes. In the 19th century, women gave birth to their children with the help of midwives, in their own home [1]. The obstetrician was requested only if there were complications at the time of delivery.

However, the increase in interventions in the pregnancy-puerperal cycle and the excessive medicalization contributed to a new scenario of parturition, in which women began to undergo procedures often without indication and their autonomy was no longer respected [2]. Health professionals, consequently, began to gain prominence when performing these procedures and became the main protagonists of this event.

Today, the importance of making the woman the protagonist of her own childbirth is perceived, guaranteeing the rights to quality care in this period of pre, trans and postpartum.

In this perspective, in view of the explanations made, the question was: How did the historical evolution happen and what are the perspectives of the process of humanization of childbirth?

The study aimed to investigate, through the literature, the historical evolution and perspectives of the humanization process of care during childbirth.

II. METHODOLOGY

This is bibliographic research considering that this is a research alternative that proposes to search and analyze the published knowledge regarding a certain theme. A search was carried out in two databases, namely: SciELO (Scientific Electronic Library Online) and LILACS (Latin American and Caribbean Literature in Health Sciences), with national publications in the last 10 years.

As a criterion for the inclusion of the sample, a search was carried out in the bases mentioned above with the Descriptors in Health Sciences (DeCS): humanized childbirth, humanization of care and obstetrics. The inclusion criteria defined for the selection of articles were: articles published in Portuguese; full articles and articles published and indexed in the aforementioned databases in the period from 2012 to 2022. Subsequently, a pre-analysis of all articles found was carried out, through the initial reading of titles and abstracts and articles that were not related to the theme. Articles published in journals were considered as analysis documents.

The review in the databases resulted in twenty-five publications. Considering the inclusion and exclusion criteria, eleven were excluded from the study, as they did not specifically address the subject studied. Therefore, fourteen publications were analyzed in full, which were suitable for the purpose of this review.

The presentation of the results and discussion of the data obtained was elaborated in a descriptive way, allowing the reader to evaluate the applicability of the elaborated review, in order to achieve the objective of this method, that is, to positively impact the performance of the nursing team, providing subsidies to the nurses in their daily decision-making.

III. RESULTS AND DISCUSSION

Considering the history of obstetrics, it is known that traditionally care during the birthing process was performed by midwives, in the comfort of their homes and under the eyes of their families.

Midwives who had empirical knowledge were trusted by women, often being part of popular classes [1]. There was still no interest on the part of the medical profession in providing care to parturient women, as they considered it a devalued health service and the responsibility of women.

The beginning of the use of obstetric forceps indicated the beginning of the modern period of obstetrics, which interfered in the performance of midwives, in which their work was devalued. This period occurred with the emergence of surgery, highlighting the pathophysiological aspects to the detriment of the psychic and cultural dimensions of women in the pre, trans and postpartum context. As a result, care for childbirth has changed, and pregnancy and childbirth, which are natural and physiological phenomena, were considered pathological and medicalized processes, changing their original essence from an existential event for mother and child into a social event [3, 4]. In this sense, the moment of delivery was institutionalized, making the presence of a doctor necessary for its performance.

In the period between 1780 and 1835, the morphological and functional bases of the female genital system were discovered and this led to the perception of childbirth as a health hazard, thus causing definitive changes in childbirth care, in which the woman as a pregnant woman was considered a woman. sick, it was when the midwives were denied intervention in this process, as pregnancy came to be considered a medical situation that requires treatment from a true medical professional [5]. In this sense, childbirth emerged as a surgical procedure that must be performed in a hospital environment [3].

During the 19th century, the fight against quackery began, a movement that blamed midwives for the high rates of maternal mortality. In this context, it was not considered that the women who were assisted were already vulnerable, living in precarious conditions, which facilitated maternal deaths. Thus, the performance of midwives suffered a sharp decline, with emphasis on childbirth performed in the hospital environment with the presence of the doctor [4].

In Brazil, in 1970, the current health model began to receive much criticism from feminist movements and other sectors of society [6]. The obstetric care model began to be questioned, predominantly characterized, among other aspects, by the institutionalization of childbirth centered on medical acts and on the use of procedures and practices considered interventionist without indication.

As early as 1980, estimates suggested that approximately 500,000 women died each year from preventable causes related to pregnancy. Hemorrhages, hypertensive diseases, sepsis, illegal abortion were considered the main causes of maternal deaths [7]. In later years, greater attention was paid to obstetric complications and some efforts were made to prevent and detect problems. Thus, greater emphasis was given to coping with obstetric complications. Therefore, in 1985, many advances were observed, but there was no significant drop in the number of maternal deaths worldwide [7].

In the 1990s, it came to be understood that women are inserted within a broader context of reproductive health and sexual rights, emphasizing the role of other factors in women's health-disease relationship, such as education, income, place of birth and degree of oppression to which women are subjected in society. Thus, these indicators would be related to maternal mortality [8]. Thus, the reduction of maternal mortality was included as one of the goals to be achieved within the Millennium Development Goals (MDGs). It is pointed out that between 2000 and 2015 more than 1.5 million deaths were avoided [9, 10].

However, unequal access to health services, care in the face of complications and inadequately provided assistance during pregnancy, childbirth and the puerperium are still major obstacles to the survival of women in the world [7].

The World Health Organization (WHO) developed a set of recommendations with the objective of clarifying the "good practices" in normal birth care, seeking to make it as physiological as possible. These recommendations were classified into four categories: Category A – useful practices that should be encouraged; Category B – practices that are demonstrably ineffective and should be eliminated; Category C – practices for which there is insufficient evidence to support a clear recommendation and which should be used with caution; Category D - practices frequently used inappropriately, disclosed in the document called Assistance to Normal Childbirth: A Practical Guide [11].

The quality of care for women at the time of childbirth is considered very important to be discussed. In this context, the Conference on Appropriate Technology for Childbirth took place. From this event, some recommendations were suggested, such as a review of the practices adopted during childbirth, excluding interventions without indication. In addition to the adoption of strategies that allow women's autonomy at the time of childbirth [6].

From this perspective, and with the intention of encouraging natural childbirth, the Ministry of Health instituted Ordinance No. dystocia performed by an obstetrician nurse" (Ordinance No. 2815/1998) [12].

In addition, Ordinance 466/2000, considering the ordinances GM/MS nº 2.816, of May 29, 1998, and GM/MS nº 865, of July 3, 1999, established as competence of the states and the Federal District the definition of limit, per hospital, of the maximum percentage of cesarean sections in relation to the total number of deliveries performed and also the definition of other strategies to obtain a reduction of these procedures within the state [13]. In addition, in 2000, the Program for Humanization in Prenatal and Birth was launched, drawing attention to the reorganization of care through the linking of prenatal care to childbirth and the puerperium (As Ordinances MS/GM 569/2000) [14].

In the current Brazilian reality, it is observed that the proportion of cesarean deliveries is one of the highest in the world, much higher than the limit of 15% recommended by the World Health Organization (WHO) to guarantee quality maternal-fetal care [9, 17]. The percentage of cesarean deliveries had relative growth in all regions of the country, from 15% in 1970 to 48.8% in 2008 [9], and in 2009 it surpassed, for the first time, that of vaginal deliveries [16]. In 2010, while the large national regions Northeast and North had proportions of cesarean deliveries of 41% and 44%, respectively, the South and Southeast had higher proportions, of 58.1% and 58.2%, respectively [17].

When there is an adequate clinical indication, cesarean section is an effective intervention to reduce maternal and neonatal morbidity and mortality. However, several non-clinical factors are related to the high number of cesarean sections, such as the association between purchasing power and access to health services for the surgical procedure, among other factors [15]. In this sense, the WHO defends that care at birth should provide the least possible intervention, prioritizing normal delivery, with safety, in order to obtain a healthy mother and child. Its recommendations for childbirth care consist of a paradigm shift, among which are: the rescue of the appreciation of the physiology of childbirth, the encouragement of a harmonious relationship between technological advances and the quality of human relationships; in addition to respecting citizenship rights [18].

Furthermore, it is known that maternal mortality remains high with around 280,000 maternal deaths worldwide each year [9], at around 210 deaths per 100,000 live births, the reduction of inequalities and the increase in of the quality of obstetric care are fundamental points for the reduction of maternal mortality [19].

Among the current health policies, the creation of Federal Law No. 11,108, which guarantees women the choice of a companion in the pre, trans and postpartum period [20], as well as the creation of Rede Cegonha, in 2011, are examples of policies positive aspects for achieving quality and humanized care. The creation of normal birth centers, within the Rede Cegonha Program, enables the active participation of obstetrician nurses in a more intense way, for the qualification of care involved in processes of autonomy of parturients, which mainly considers their active participation at the moment. of childbirth and respect for their therapeutic choices [6].

In this way, it is clear that the humanization of care during childbirth is very current, and requires efforts from all the subjects involved, seeking to guarantee women with quality and comprehensive care, which requires all actors involved with health care. efforts to abolish aggressive behavior.

IV. CONCLUSION

It was concluded that the discussion about the humanization of childbirth is current and still happens as a reaction to several issues such as: routine cesarean section and use of enema, shaving, amniotomy, intravenous oxytocin, episiotomy without indication, as well as the need for attention adequate and quality by the professionals.

In this way, the practice of humanization arises from an attempt to direct a different look at the role of women at the moment of childbirth, considering their anxieties, desires, beliefs and life context.

The movement for the humanization of childbirth shows that the issue of birth is also the responsibility of the government and, given current problems such as those related to the infrastructure weaknesses of the health network in Brazil, it is also a public health issue. From this perspective, public policies must have guiding directions for the realization of these points and guarantee quality care.

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