THE SPEECH AND PRACTICE OF HUMANIZING CHILDBIRTH IN ADOLESCENTS[1]

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ABTRACT: This descriptive study aimed to identify the childbirth care practices developed by health professionals towards adolescent parturients. Data were collected from the database of the study "Humanizing Childbirth Care in Adolescents", developed in the city of Pelotas-RS, by means of semi-structured interviews, between 2008 and 2009. The study population consisted of health workers from the obstetric center of a public teaching hospital. The analysis was systematized as per the guide Care in Normal Birth, published by the World Health Organization. Results evidenced that useful practices, such as intimacy and privacy, choice of the type of childbirth and breastfeeding encouragement are not respected. The harmful practices that stood out were the use of the lithotomy position and oxytocin. Examples of practices that are frequently developed inappropriately are food restriction and the use of amniotomy. In conclusion, childbirth care practices partially complied with the Humanizing Labor and Childbirth Policy.

DESCRIPTORS: Adolescent. Women's health. Humanizing childbirth. Nursing.

O DISCURSO E A PRÁTICA DO PARTO HUMANIZADO DE ADOLESCENTES

RESUMO: Estudo descritivo que objetivou conhecer as práticas de atenção ao parto desenvolvidas pelos profissionais de saúde no cuidado à parturiente adolescente. Os dados foram extraídos da pesquisa "Atenção humanizada ao parto de adolescentes", referente ao Município de Pelotas-RS, por meio de entrevistas semiestruturadas, no período de 2008 a 2009. A população constituiu-se de profissionais de saúde do centro obstétrico de um hospital de ensino público. A análise foi sistematizada a partir do Manual Assistência ao Parto Normal, da Organização Mundial de Saúde. Os resultados evidenciaram que práticas úteis, como a intimidade e a privacidade, escolha do tipo de parto e o estímulo à amamentação, não são respeitadas. Como práticas prejudiciais salientaram-se a posição de litotomia e o uso da ocitocina. Destacaram-se como práticas inadequadas a restrição alimentar e a utilização da amniotomia. Concluiu-se que as práticas de atenção ao parto contemplaram parcialmente a Política de Humanização do Parto e Nascimento.

DESCRITORES: Adolescente. Saúde da mulher. Parto humanizado. Enfermagem.

EL DISCURSO Y LA PRÁCTICA DEL PARTO HUMANIZADO EN ADOLESCENTES

RESUMEN: Este estudio descriptivo objetivó conocer las prácticas de atención al parto desarrolladas por los profesionales de salud en el cuidado de la mujer adolescente. Los datos fueron extraídos del banco de datos de la investigación "Atención humanizada al pParto de aAdolescentes" referente al Municipio de Pelotas-RS, por medio de entrevistas semiestructuradas en el período de noviembre de 2008 a octubre de 2009. La población meta se constituyó de los profesionales de salud actuantes en el Centro Obstétrico de un hospital de enseñanza pública El análisis fue sistematizado a partir del Manual Asistencia al Parto Normal, de la Organización Mundial de la Salud, referente a las prácticas de atención al parto consideradas útiles, aquellas claramente perjudiciales y las frecuentemente utilizadas de forma inadecuada. Los resultados evidenciaron que prácticas útiles, como la intimidad y la privacidad, opción por el tipo de parto y el estímulo para amamantar, no son respetadas; como prácticas perjudiciales, se destacaron la posición de litotomía y el uso de la ocitocina. Cuanto a las prácticas inadecuadas, se destacaron la restricción alimentar y la utilización de la amniotomía. Se concluyó que las prácticas de atención al parto contempla parcialmente la Política de Humanización del Parto y Nacimiento.

DESCRIPTORES: Adolescente. Salud de la mujer. Parto humanizado. Enfermería.

INTRODUCTION

The search for the humanization of care in childbirth is a theme of growing interest, even though the meanings, contents and purposes of this type of care remain a great challenge, since they demand health professionals to be prepared to assist the pregnant woman and her companions, respecting the true meaning of this moment.

Aimed to minimize inappropriate and unnecessary childbirth practices, the World Health Organization (WHO) published, in 1996, the Care in Normal Birth: A Practical Guide, a reference for the implementation of the humanizing childbirth in the health services. This guide indicates the current and recommended obstetric practices, based on scientific evidence, and classifies them into four categories: practices which are demonstrably useful and should be encouraged; practices which are clearly harmful or ineffective and should be eliminated; practices for which insufficient evidence exists to support a clear recommendation and which should be used with caution; and practices which are frequently used inappropriately, causing more harm than good.[1]

Based on the recommendations of the WHO and aimed to meet the singularities of each woman in the parturition process, the Ministry of Health (MH), in 2000, implemented a broad process of humanization in obstetric care through the Prenatal and Childbirth Humanization Program (PCHP). This strategy aims to recover the integrated, qualified and humanizing obstetric care during prenatal, childbirth and postpartum, with the involvement of the states and municipalities both in the public and private sectors.[2]

Hence, the PCHP points out the need for comprehensiveness in obstetric care, assuring women's rights as per institutional guidelines, reorganizes the care in labor, formally bonding prenatal care to childbirth and postpartum, and proposes the expansion of women's access to the healthcare network, providing quality care with the least interventions.[3-4]

Humanizing care involves the union of technical and scientific competences to ethical principles, respecting the individuality of the human being. Care planning must appreciate the human being, meeting their specificities and needs. Hence, the circumstances involving each particular human being must be respected and health actions must focus on the interactions between subjects.[5-7]

Hospital institutions remain centered at providing a care based on interventionist actions, in which quality involves more than the resolution of problems or the use of technology, requiring attitudes and behaviors from the health workers that contribute to reinforce health care as a human right. It is necessary to improve the degree of information of the parturients regarding their health conditions and to increase their autonomy so they make appropriate choices in their parturition process.[8]

Therefore, a more effective care means providing actions and services based on the singularities of the parturients, different from what is observed in the health institutions, where the needs of the institutions and/or professionals overlays the needs of the health service users.

Pregnancy in adolescence has been the subject of countless debates in the public health area, gaining greater social visibility to this specific group in the parturition process. Both the pregnant woman and the adolescent parturient deserve special attention, thus, it is important for health professionals to be sensitive to understand the adolescent in her singularities, respecting her origin, culture and choices, providing qualified, individualized and more humane care, which is a right to every citizen, and acknowledging the pregnant adolescent as an active subject in the health production process.[5-6,9]

The relevance of the present study stands on the production of knowledge based on the proposal of care humanization to the health of female adolescents, aimed to learn the differences between the recommendation of the Ministry of Health and what is, effectively, practiced. In this context, this study aimed to answer the following study question: Which practices have been developed by health professionals to provide humanizing care to the adolescent parturient?

The purpose of this study was to identify the childbirth care practices developed by health professionals in the care to the adolescent parturient.

METHODOLOGY

This exploratory descriptive study, with a quantitative approach, derives from the multicentric research "Humanizing childbirth care in adolescents", which involved two public universities in the Brazilian state of Rio Grande do Sul: the Federal University of Rio Grande (FURG), in the city of Rio Grande, and the Federal University of Pelotas (UFPEL).

The study setting was the Obstetric Center (OC) of a teaching hospital in the city of Pelotas-

RS, which is a reference institution for extremely low-weight premature babies and high-risk childbirths. The target population consisted of 48 health professionals who effectively worked in the OC, namely: seven nurses, 12 nursing technicians, 12 nursing assistants, seven intern physicians and 10 teaching physicians. Data were extracted from an instrument applied to the health workers.

The present study complied with the resolution 196/96 of the National Health Council of the MH.[10] The research proposal was approved by the Health Research Ethics Committee of FURG, on May 14, 2008, under the protocol n. 031/2008.

Data were individually collected in the work location of the participants, in the period between November 2008 and October 2009, by means of semi-structured interviews, previously scheduled according to the availability of each professional.

The variables used were: privacy and intimacy, follow-up, guidance regarding the childbirth, guidance regarding relaxation techniques, types of childbirth, hygiene measures, early mother-baby contact, breastfeeding encouragement, breastfeeding in the baby's first hour of life, relationship of the team with the parturient and her family members, common use of enema, common use of the trichotomy, use of oxytocin, childbirth position, common use of episiotomy, food intake and amniotomy. In order to understand the reality of this study, the variables were grouped in: care practices in normal birth which are demonstrably useful and should be encouraged; practices which are clearly harmful or ineffective and should be eliminated; and practices which are frequently used inappropriately. This classification was based on the guide Care to Normal Birth of the WHO, incorporated by the Ministry of Health into the PCHP.[1-2]

The collected data were reviewed and stored by double entry, by different typists; being later compared and corrected. The stages of data analysis were developed using Epi-Info 6.04, using descriptive analysis with calculation of the proportions for the categorical variables.

The discussion of the results was grounded on the Humanizing Labor and Childbirth Policy.

RESULTS

Among all 48 health professionals, 25% were men and 75% were women, and as for their field: 15% were nurses, 25% were nursing aides, 25% nursing technicians, 15% intern physicians and 20.8% teaching physicians.

Table 1 presents the proportion of normal birth care practices that are demonstrably useful and should be encouraged, according to the speech of health professionals from the studied OC.

Table 1 - Normal birth care practices, which are demonstrably useful, developed by health professionals from the obstetric center of a teaching hospital in Pelotas-RS, Brazil, November 2008 to October 2009

Variable	n (48)	%
Privacy and intimacy		
Yes	19	39.6
No	8	16.6
Sometimes	21	43.8
Companion		
Yes	47	97.9
Does not know	1	2.1
Relationship of the team with parturient and family		
Reasonable/Good	31	64.6
Very good/Excellent	17	35.4
Guidance regarding childbirth		
Yes	42	87.5
Sometimes	6	12.5
Guidance regarding relaxation techniques		
Yes	32	66.7
No	16	33.3
Choice of the type of childbirth		
No	46	95.8
Sometimes	2	4.2
Hygiene measures		
Yes	41	85.4
No	1	2.1
Sometimes	6	12.5
Mother/child contact		
Yes	25	52.1
No	23	47.9
Breastfeeding encouragement		
Yes	15	31.2
No	33	68.8
Breastfeeding in the baby's first hour of life		
0 to 60 minutes	48	100.0

Regarding the respect to the privacy and intimacy of the parturients, most professionals (44%) answered that these aspects are sometimes respected during labor and childbirth. The right to having a companion was referred by 98% of the health professionals and 65% considered the relationship of the team with the parturient and her family reasonable or good. Most of the profession-

als (67%) stated they guide parturients regarding the childbirth and ways to relax in order to relieve pain. For 96% of the professionals, the parturient cannot choose the type of childbirth she wants. As for comfort and hygiene measures, 85% of the professionals stated that these measures were observed in the OC. When questioned regarding the early contact of the mother with the baby, half the professionals (52%) identified that this contact takes place, however, 69% of them said they did not encourage breastfeeding, even though all professionals stated the baby was breastfed in the first hour of life.

Table 2 presents the results of the proportion of normal birth care practices that are clearly harmful or ineffective and should be eliminated, according to the health professionals of the studied OC.

Table 2 - Normal birth care practices that are clearly harmful, developed by health professionals from the obstetric center of a teaching hospital in Pelotas-RS, Brazil, November 2008 to October 2009

Variable	n (48)	%
Use of enema		
No	48	100.0
Use of trichotomy		
Yes	1	2.1
No	47	97.9
Infusion of IV with oxytocin		
Yes	44	91.7
No	4	8.3
Childbirth position		
Lithotomy	48	100.0
Common use of episiotomy		
Yes	28	58.3
No	20	41.7

The interviewed professionals did not confirm the use of enema. As for trichotomy, only one of the professionals still uses the routine technique. Regarding the use of infusion of IV with oxytocin, 92% of the professionals confirmed its use and 100% of the professionals stated they use the lithotomy position during childbirth. Episiotomy was performed by 58% of the professionals from the studied OC.

Table 3 presents the result of the proportion of normal birth care practices which are frequently used inappropriately, according to the health professionals of the studied OC.

Table 3 - Normal birth care practices that are frequently used inappropriately by health professionals from the obstetric center of a teaching hospital in Pelotas-RS, Brazil, November 2008 to October 2009

Variable	n (48)	%
Food intake		
Yes	14	29.2
No	12	25.0
Sometimes	22	45.8
Routine amniotomy		
Yes	37	77.1
No/Does not know	11	22.9

For 46% of the health professionals, sometimes the parturients could eat, and most of them (77%) stated amniotomy is commonly used in the studied OC.

DISCUSSION

The findings of this study permitted to learn the practices developed by the health professionals in the OC of the studied hospital. The respect to the privacy and intimacy of the parturient is a demonstrably useful practice that should be encouraged, however, professionals respected it only occasionally. A similar study developed in the city of Rio Grande-RS, revealed that approximately 70% of the professionals stated they respected the privacy and intimacy of the adolescent parturient.[11]

Regarding obstacles found in the assurance of the parturient's right to privacy and intimacy, other Brazilian studies point out the authoritarian and asymmetrical relationship between health professionals and parturients, poor structural conditions and professional and institutional practices that do not incorporate comprehensively the idea of childbirth as a family event and reproductive right to the obstetric care.[4,12]

In some health institutions, the right to a companion during labor and childbirth is denied, as it may be observed in the findings regarding a maternity hospital in Rio de Janeiro-RJ, in which the care delivered in labor and childbirth followed predominantly the technocratic medical model, consequently leading to the denial of several rights to the women, among those the right to have a companion of her choosing in the moment of childbirth.[13] Similar findings were revealed in a study developed in Rio Grande-RS, in which 83% of the professionals stated they denied to the parturient the right to have a companion of her choosing.[11]

Japanese health institutions, with the purpose to establish the improvement of childbirth care, verified that the institutional strategies and rules restricting the presence of a companion in childbirth were the main barrier for the humanizing childbirth care. Among nine studied health institutions, only three allowed the presence of a companion in labor and childbirth.[14]

Different from these institutions, in the OC of the hospital in this study, health professionals assured the parturient's right to have a companion of her choosing.

Considering interpersonal relationships, two thirds of the professionals described the relationship of the team to the parturient and her family members as reasonable or good. Other studies also indicate this relationship as being, mostly, reasonable or good.[11-13,15]

According to the health professionals participating in this study, the parturients received guidance regarding the childbirth. This result is similar to that of the study developed in Rio Grande-RS, in which 91% of the health professionals stated they provided guidance to the adolescent parturients regarding the childbirth.[11]

From a different perspective, a study developed in two hospitals associated with the Unified Health System (*Sistema Único de Saúde* - SUS), in the city of Maringá-PR, identified the insufficiency and denial of information regarding the childbirth as being one of the obstacles for the implementation of humanizing childbirth.[12] However, evaluating the perspective of the parturient, a study developed in a public hospital in Fortaleza-CE found lower proportions, as 40% of the parturients stated they received guidance regarding the childbirth.[16]

Regarding relaxation techniques for pain relief, in this study, most of the health professionals stated that, basically, they instruct the parturients to perform breathing techniques. At *São Sebastião* Birthing Center, Distrito Federal, the parturient is free to move, walk, take a shower, and receives guidance regarding non-pharmacological methods to relieve pain.[17] In the study developed with adolescent parturients in Fortaleza-CE, this perspective is similar, as 63% of the interviewed parturients mentioned they had received some guidance on ways to relax in order to relieve pain.[16]

These prerogatives were also found in a study developed in Maringá-PR, as 67% of the interviewees indicated they had received guidance on, at least, one non-pharmacological method to relieve labor pain, and the most frequently used methods were shower and breathing exercises.[12]

For most of the professionals, the parturients could not choose the type of childbirth they wanted to adopt. Similarly, in the study developed in Rio Grande-RS, 96% of the health professionals stated the women could not choose the type of childbirth they wanted either.[11]

Aimed to identify the preferences of the pregnant women as for the type of childbirth they wanted to have, a study with primiparous women from a city in São Paulo observed that 75% of the pregnant women preferred normal birth, 15% preferred cesarean section and 10% had not chosen the type of birth yet. The main reason for this choice was the short time of recovery (62%), followed by the thought that this is a healthier type of childbirth for both mother and child.[18]

As recommended by the Ministry of Health,[19] in this study, comfort and hygiene measures were encouraged during labor and childbirth. Similarly, in the study in Rio Grande-RS, 87% of the professionals also stated this practice was developed.[11]

Regarding the practices involving mother and child, this study identified that all professionals in the studied hospital complied with the breastfeeding practice in the baby's first hour of life. However, the early contact between mother and child was not always encouraged and most of the professionals did not encourage the parturient to breastfeed.

Not so differently, a study developed in Santa Catarina revealed that most of the children were not delivered to their mothers right after birth, however, after the first care measures, all babies were taken to their mothers to be breastfed.[15] In the hospital in Rio Grande-RS, on the other hand, most of the professionals encouraged the mother-child early contact and the breastfeeding practice in the first hour of life.[11] Similar results were found in Fortaleza-CE, as 33% of the adolescent parturients were encouraged to breastfeed their babies in their first hour of life.[16]

Considering practices that are clearly harmful or ineffective and should be eliminated, this study revealed that the interviewed health professionals did not mention the use of enema. Nevertheless, the study in Santa Catarina showed that this practice was still commonly used in some health institutions.[15]

In the present study, only one of the health professionals mentioned the use of trichotomy as a usual technique. However, this practice is still

present in the routine of some institutions, according to the study developed in Rio Grande-RS, as 70% of the health professionals mentioned the use of this practice routinely.[11] In Santa Catarina, professionals reported the use of techniques, such as trichotomy, that inhibit the security and well-being of the parturient.[15]

Regarding the infusion of IV with oxytocin, this study indicated that health professionals used this practice most of the times. In a study developed in Canada, the women in the cohort of assisted planned home childbirth were less likely to having their childbirth accelerated with the use of oxytocin, when compared to the hospital childbirth cohort.[20] Another study, developed in Portugal, compared the use of prostaglandin to induce childbirth according to the age range, and revealed that 27% of the women over 20 years of age were submitted to childbirth induction, whereas in the groups under 20 and 16 years of age this proportion decreased to 17%.[21]

This study identified that the lithotomy position for childbirth was used in all normal births. A case-control study developed in a public maternity hospital and a maternity hospital associated with the SUS, in the city of Rio de Janeiro-RJ, showed that the lithotomy position was frequently adopted for normal birth in both hospitals; with a use rate of 98% in the public maternity hospital and 99% in the hospital associated with the SUS.[22]

In the perspective of the parturients from Fortaleza-CE, the lithotomy position was adopted for childbirth in 63% of the cases, whereas 33% adopted the semi-squatting position and 3% used lateral position.[16]

Based on scientific evidence, the WHO and the MH recommend the restricted use of episiotomy and classify its common and liberal use as a clearly harmful practice, which should be discouraged, as it is indicated in only approximately 10% to 15% of the cases.[18] This study indicated that episiotomy was frequently performed by most of the health professionals, and similar results were found in other studies.[11-15]

A study developed in Canada showed that the women in the assisted planned home birth were less likely to being submitted to episiotomy.[20] The study developed in Portugal evidenced that episiotomy was a usual practice, since, all women interviewed, who had a normal birth, suffered episiotomy.[21]

Among the practices that are frequently used inappropriately in normal birth, water and food intake was not always allowed in the studied OC. The comparison of the result of this variable with other studies showed that there is still not a consensus on the subject. In the cross-sectional study developed in Maringá-PR, parturients without prior cesarean section experience and multiparous women with prior normal birth experience received liquids orally during labor with more frequency.[12] At São Sebastião Birthing Center, in Distrito Federal, the parturient was allowed to consume liquids during the process of parturition.[17] On the other hand, the study developed in Santa Catarina showed that professionals did not offer liquids to the parturient during labor and childbirth.[15]

Regarding the use of amniotomy, this study indicated that only a quarter of the health professionals did not use this practice. Similar results are reported by professionals from Rio Grande-RS.[11]

A study developed in Rio de Janeiro-RJ observed a high proportion of amniotomies developed prematurely (with seven cm or less of dilatation). Amniotomy was more frequently used in the maternity hospital associated with the SUS than in the public maternity hospital, and more frequent in the normal birth group than in the cesarean section group. More than a third of the women who had a normal birth, in both hospitals, were submitted to this practice.[22]

FINAL CONSIDERATIONS

After over a decade from the implementation of the Prenatal and Childbirth Humanization Program, several hospital institutions are still centered in the care model based on interventionist actions. However, it is fundamental to fight the irregularities between the speech and practice in the routine care delivered to adolescents in the parturition process, minimizing the distance between the recommendation of the Ministry of Health and what is effectively practiced in the childbirth settings.

In this study, it was possible to verify that several practices which are considered useful for the humanizing childbirth were being developed in the studied OC, such as the right to having a companion, guidance on the childbirth, guidance of relaxation techniques to relieve pain, a good relationship of the team with the parturient and her family members, comfort and hygiene measures, and breastfeeding in the baby's first hour of life. However, it was evidenced that clearly

harmful or ineffective practices were still used, such as the common use of the lithotomy position in childbirth, the infusion of IV with oxytocin and the common use of episiotomy. As for practices that are frequently used inappropriately in childbirth care, food restriction and the common use of amniotomy stand out.

The findings of this study, regarding breastfeeding, indicated a contrasting point, since most of the professionals did not encourage breastfeeding. Nevertheless, all professionals answered that the baby was breastfed in the first hour of life. Hence, the authors suggest the development of new studies with health professionals involved in the care of adolescent pregnant women aimed to figure out this contrasting aspect. In this perspective, the practices developed in the childbirth care of adolescents, in the studied hospital, still do not contemplate comprehensively the Humanizing Labor and Childbirth Policy, recommended by the Ministry of Health.

In order to change the childbirth care delivered to adolescents, it is vital review the organization of obstetric practices in Brazilian maternity hospitals. Establishing programs and instituting health policies is not enough, since it is fundamental for educational institutions, especially in the medical and nursing areas, to review the role of the health professional in labor and childbirth care, and to make adjustments in the educational process, assuring humanizing care, guided by the rights of the patients and based on evidence. In this professional education setting, nursing is believed to play an essential role in the change of childbirth care practices, since the humanist and supportive education of the nurse may serve to articulate the operation of the Humanizing Labor and Childbirth Policy.

The results observed in this study may contribute as a warning, in the sense of building a humanizing childbirth care proposal aimed at adolescents, transforming the study location into a place focused on practices that aim at the promotion of a healthy labor and childbirth, respecting the physiological process, the dynamics of each childbirth and returning to the woman the leading role in the parturition process.

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