Reinventing delivery and childbirth in Brazil: back to the future

Para reinventar o parto e o nascimento no Brasil: de volta ao futuro

Para reinventar el parto y el nacimiento en Brasil: regreso al futuro

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The demonstrations that took the streets in Brazil in June 2013 brought health care to the center of public debate. The protests exposed the limits of the Brazilian Unified National Health System (SUS): despite expanding care coverage enormously, it is unable to assure service quality and suffers from chronic underfunding and management shortcomings. Moreover, the model of health care financing accentuates social inequalities. The poorer majority finds difficulty enjoying the universal right to public health services stipulated in the 1988 *Federal Constitution*. Meanwhile, 25% of Brazilians hold private health insurance, but benefit from substantial tax waivers by the State, which – although sustained by taxes paid by the population at large – finances access to generally better-quality care for a privileged minority [1]. The SUS also suffers the adverse effects of (mis-)trained health professionals, especially physicians unprepared for primary care, as laid bare by the closed-shop reaction to the *Mais Médicos* (More Physicians) program, which imported foreign doctors into underserved areas of Brazil.

These problems take on specific configurations in the technocratic model of care at childbirth, which is characterized by the primacy of technology over human relations and a purported value neutrality [2]. The model rests on the idea that women are to remain passive, immobile during childbirth, while they undergo interventions by unknown health personnel to shorten the time to birth [3]. Unnecessary and harmful procedures are used to the maximum, as dictated by the reigning mercantile logic and medical (mis-) training. This is most visible in the growing epidemic of caesarean sections [4].

The results of the *Birth in Brazil* survey have confirmed at the national level the panorama described in local studies and condemned by women's movements and movements to humanize childbirth [2]. They constitute compelling evidence of socioeconomic, racial and regional inequalities in care at childbirth [5,6,7].

The technocratic model figures differently in the SUS and in private 'supplementary care', accentuating inequalities in the quality of hospital delivery, which has attained universal coverage [4]. In public services, there is often a disconnect between antenatal care and care at childbirth [8], facilities repeatedly denying admission [8], and routine use of episiotomy and oxytocin [3,7]. In private services, most deliveries are by scheduled caesarean, even among first-time mothers [4,9,10]. In both sectors, the right to information is not assured nor is women's autonomy respected, their bodily integrity is violated and their legally-assured right to a companion is denied [6], making childbirth lonely, unsafe and painful [11].

Measures to change this situation have reflected political and ideological struggles in the health field over alternative models of care since Brazil introduced the Women's Comprehensive Health Care Program (PAISM) in 1983, as the outcome of converging proposals by the sanitary and feminist movements [12].

Feminism aspires to overcome the 'mother-and-child' approach and incorporate the notion of women as subjects, going beyond their specific reproductive role and assuring a broader approach to health care. The humanization of childbirth is framed by the broader umbrella of sexual and reproductive rights, which include the guarantee of safe maternity, contraception and abortion [12].

Health is central to the feminist agenda, which criticizes the biomedicine that provides grounds on which to justify hierarchical gender relations. Concretely, feminists have worked to occupy monitoring and social control instances of public policy and militant activism in management positions [12].

However, organized action by conservative and religious forces is growing in parliament and government, and threatening the lay State. In the Ministry of Health, these groups' influence has resulted in policy back-pedaling and a strengthening of the 'mother-and-child' approach [13].

Introduction of the *Rede Cegonha* (Stork Network) strategy represents, symbolically and materially, a downgrading of both the feminist agenda and construction of the SUS. Its very name desexualizes reproduction, placing the emphasis on the conceptus [13]. It disconnects care at childbirth from the national Policy of Women's Comprehensive Health Care (PNAISM) and reinforces the "mother-and-child" approach in policy priority-setting. It obscures unsafe abortion in a context of strongly declining fertility.

The symbolic dimension is no minor issue if the present model of public financing is maintained. Poverty reduction is fostering inclusion for social groups anxious to consume goods and services, for instance, childbirth by cesarean section. The distortions may be heightened by the induction of "new consumers", who perceive access to technology as a sign of social prestige and modernity [11].

What are in dispute are different projects of society, as regards construction of the SUS and gender equity in health. It is in this scenario that the opportunities to change care at childbirth emerge. The solutions are not purely technical, but essentially political. Changes cannot be achieved without reinstating the project of a democratic SUS and the health sector reform's guiding principles of universality, comprehensiveness and equity, as written into the Constitution. It is essential to defend the lay, democratic and plural State and to emphasize the intersection among gender, social class, race/ethnicity and sexuality in producing/reproducing social inequalities in health. It is imperative to assure that care is humanized on the basis of scientific evidence, but also on the basis of women's rights, in order to redefine care practices and interpersonal relations [2].

It is inspiring to revisit the 1980s and their radicalness, so as to re-politicize health needs and once again broaden the agenda for formulation and implementation of public policies directed to women.

1. Paim J, Almeida-Filho N, Vieira-da-Silva L. Saúde coletiva: futuros possíveis. In: Paim J, Almeida-Filho N, organizadores. Saúde coletiva: teoria e prática. Rio de Janeiro: Medbook Editora Científica; 2013. p. 669-86.
2. Diniz CSG. Humanização da assistência ao parto no Brasil: os muitos sentidos de um movimento. Ciênc Saúde Coletiva 2005; 10:627-37.
3. Diniz SG, Chacham AS. "The cut above" and "the cut below": the abuse of caesareans and episiotomy in Sao Paulo, Brazil. Reprod Health Matters 2004; 12:100-10.
4. Victora CG, Aquino EM, Leal MC, Monteiro CA, Barros FC, Szwarcwald CL. Maternal and child health in Brazil: progress and challenges. Lancet 2011; 377:1863-76.
5. d'Orsi E, Brüggemann OM, Diniz CSG, Aguiar JM, Gusman CR, Torres JA, et al. Desigualdades sociais e satisfação das mulheres com o atendimento ao parto no Brasil: estudo nacional de base hospitalar. Cad Saúde Pública 2014; 30 Suppl:S154-68.
6. Diniz CSG, d'Orsi E, Domingues RMSM, Torres JA, Dias MAB, Schneck CA, et al. Implementação da presença de acompanhantes durante a internação para o parto: dados da pesquisa nacional *Nascer no Brasil*. Cad Saúde Pública 2014; 30 Suppl:S140-53.
7. Leal MC, Pereira APE, Domingues RMSM, Theme Filha MM, Dias MAB, Nakamura-Pereira M, et al. Intervenções obstétricas durante o trabalho de parto e parto em mulheres brasileiras de risco habitual. Cad Saúde Pública 2014; 30 Suppl:S17-47.
8. Viellas EF, Domingues RMSM, Dias MAB, Gama SGN, Theme Filha MM, Costa JV, et al. Assistência pré-natal no Brasil. Cad Saúde Pública 2014; 30 Suppl:S85-100.
9. Gama SGN, Viellas EF, Schilithz AOC, Theme Filha MM, Carvalho ML, Gomes KRO, et al. Fatores associados à cesariana entre primíparas adolescentes no Brasil, 2011-2012. Cad Saúde Pública 2014; 30 Suppl:S117-27.
10. Domingues RMSM, Dias MAB, Nakamura-Pereira M, Torres JA, d'Orsi E, Pereira APE, et al. Processo de decisão pelo tipo de parto no Brasil: da preferência inicial das mulheres à via de parto final. Cad Saúde Pública 2014; 30 Suppl:S101-16.
11. Diniz SG. Gênero, saúde materna e o paradoxo perinatal. Rev Bras Crescimento Desenvolv Hum 2009; 19:313-26.
12. Costa AM. Participação social na conquista das políticas de saúde para mulheres no Brasil. Ciênc Saúde Coletiva 2009; 14:1073-83.
13. Diniz S. Materno-infantilism, feminism and maternal health policy in Brazil. Reprod Health Matters 2012; 20:125-32.

Submitted on 21/Jan/2014
Approved on 28/Jan/2014