

Federal University of Rio de Janeiro State



# Journal of Research Fundamental Care Online

ISSN 2175-5361  
DOI: 10.9789/2175-5361

## RESEARCH

### A assistência humanizada no trabalho de parto: percepção das adolescentes

The humanized assistance in parturition: the perception of teenagers

La asistencia humanizada en el trabajo de parto: la percepción de los adolescentes

Pricilla Braga Vargas <sup>1</sup>, Bianca Dargam Gomes Vieira <sup>2</sup>, Valdecyr Herdy Alves <sup>3</sup>, Diego Pereira Rodrigues <sup>4</sup>, Diva Cristina Morett Romano Leão <sup>5</sup>, Luana Asturiano da Silva <sup>6</sup>

### ABSTRACT

**Objective:** to identify the perceptions of teenagers in thier assistance offered at the time of labor and delivery; discuss these perceptions with the humanized care in labor and delivery. **Method:** this is a descriptive, exploratory, qualitative, with fifteen teens /postpartum women's rooming Maternity Oswaldo Nazareth city of Rio de Janeiro, through semi-structured interviews and analyzed with the principles of thematic analysis, after approval Ethics Committee of SMSDS-RJ under number 223/11. **Results:** the perception identified in the obstetric care team, such as the importance of the companion is a woman's right, and the inclusion of institutionalized practices, such as the medicalization of the body, food restriction and bath. **Conclusion:** it has a direct impact on the imagination of the birth process, with the empowerment of women towards their free and informed choices. **Descriptors:** labor obstetric, parturition, adolescent.

### RESUMO

**Objetivo:** identificar as percepções das adolescentes em relação á assistência oferecida no momento do seu trabalho de parto e parto; discutir essas percepções com a assistência humanizada no trabalho de parto e parto. **Método:** trata-se de uma pesquisa descritiva, exploratória, de natureza qualitativa, com quinze adolescentes/puérperas do alojamento conjunto da Maternidade Oswaldo de Nazareth da cidade do Rio de Janeiro, mediante entrevista semiestruturada e analisado com os preceitos da análise temática, após aprovação pelo Comitê de Ética da SMSDS-RJ, sob nº 223/11. **Resultados:** permitiu identificar a percepção na atenção da equipe obstétrica, como a importância do acompanhante, sendo um direito da mulher, e a inserção de práticas institucionalizadas, como a medicalização do corpo, restrição de alimentos e banho. **Conclusão:** isso repercute diretamente no imaginário do processo parturitivo, com na autonomia da mulher perante as suas escolhas livres e informadas. **Descritores:** Trabalho de parto, parto, adolescente.

### RESUMEN

**Objetivo:** identificar las percepciones de los adolescentes en la asistencia emabarasso ofrecido en el momento del parto; discutir estas percepciones con la atención humanizada en el parto. **Método:** se trata de una aprobación descriptivo, exploratorio, cualitativo, con quince adolescentes/alojamiento conjunto de maternidad de las mujeres después del parto Oswaldo Nazaret, ciudad de Río de Janeiro, a través de entrevistas semi-estructuradas y analizadas con los principios de análisis temático, después de Comité de Ética de SMSDS-RJ con el número 223/11. **Resultados:** la percepción identificada en el equipo de atención obstétrica, tales como la importancia de la compañía es el derecho de la mujer, y la inclusión de las prácticas institucionalizadas, como la medicalización del cuerpo, la restricción de alimentos y bañera. **Conclusión:** tiene un impacto directo en la imaginación del proceso del nacimiento, con el empoderamiento de las mujeres con respecto a sus decisiones libres e informadas. **Descriptor:** trabajo de parto, parto, adolescente.

<sup>1</sup>Nurse, graduated from the Nursing School Aurora de Afonso Costa, Fluminense Federal University, Niterói, Rio de Janeiro, Brazil. Email: prizinha\_braga@hotmail.com. <sup>2</sup>Nurse, Master in Nursing from the School of Nursing Anna Nery, Federal University of Rio de Janeiro, Rio de Janeiro, Brazil. Assistant Professor of the Maternal and Child Psychiatry Department, School of Nursing Aurora de Afonso Costa, Fluminense Federal University, Niterói, Rio de Janeiro, Brazil. Email: biadargam@gmail.com. <sup>3</sup>Nurse, PhD in Nursing from the School of Nursing Anna Nery, Federal University of Rio de Janeiro, Rio de Janeiro, Brazil. Professor of Maternal and Child Psychiatry Department, School of Nursing Aurora de Afonso Costa, Fluminense Federal University, Niterói, Rio de Janeiro, Brazil. Email: herdyalves@yahoo.com.br. <sup>4</sup>Nurse, Master's Student in Health Care Sciences School of Nursing Aurora de Afonso Costa, Fluminense Federal University, Niterói, Rio de Janeiro, Brazil. Email: diego.pereira.rodrigues@gmail.com. <sup>5</sup>Nurse, Master in Nursing from the State University of Rio de Janeiro, Rio de Janeiro, Brazil. Assistant Professor of Maternal and Child Psychiatry Department, School of Nursing Aurora de Afonso Costa, Fluminense Federal University, Niterói, Rio de Janeiro, Brazil. Email: divaleao@yahoo.com.br. <sup>6</sup>Nurse graduated from Nursing School Aurora de Afonso Costa, Fluminense Federal University, Niterói, Rio de Janeiro, Brazil. Member of the Research Group: Maternity, Women's and Children's Health. Email: luanaasturiano@hotmail.com.

## INTRODUCTION

**H**umanization of obstetric care has been implemented as a working philosophy aiming at a greater physical and mental comfort for mothers and for babies, as will several benefits to both, and breaking as the medicalization of childbirth, use of health practices without proof of your benefit, besides the rescue of women as the main figure in parturition process.<sup>1</sup>

This is humanized through strategies such as rooming-in, breastfeeding promotion still in the delivery room, the presence of family members or companions, beyond redemption natural physiological birth and character, but this implementation has not occurred in many places, and others has been occurring slowly.<sup>2</sup>

The historically childbirth care was exclusively female responsibility, because only midwives performed this practice.<sup>3</sup> It is known that they were known by their experiences in society, though not dominate scientific knowledge.

However, from the twentieth century, intensified hospitalization of childbirth, which allowed control and medicalization of pregnancy and puerperal period, and birth as a natural, private and family process, became experienced in the public sphere, in health institutions in the presence of various actors conducting this period.<sup>4</sup>

Therefore, since the beginning of time, even though women have programmed your body to reproduction of the species, practices and customs that involve childbirth has varied over the years, in different and distinct cultures, mainly due to the incorporation of new technologies in medicine.<sup>5</sup>

The woman lost her privacy and autonomy, the family was separated and subjected to institutional standards and interventionist practices without proper explanation and consent of the woman in labor. Thus, the delivery can often be experienced as a moment of intense physical and moral suffering.

The fear, tension and pain of women in labor in hospital-centered model of care, prevent the physiological process of normal birth, which may culminate in interventionist practices that most often could be avoided.

This panorama medicalization of childbirth began to change with the Program for Humanization of Prenatal and Birth (PHPN) which was established by the Ministry of Health through Ordinance/GM n° 569/2000. The program advocates for labor, delivery and birth, with intention to redeem the physiological character positively and without trauma to the woman.<sup>6</sup>

The primary objective of PHPN is to ensure improved access, coverage and quality of prenatal care, childbirth care to pregnant and postpartum and newborn care, from the perspective of citizenship rights. With the humanization process, the physical and emotional comfort of the pregnant woman can be increased by the use of massage techniques and

relaxation, varied postures, music, breathing methods and practical alternatives that promote sound development of labor providing comfort and safety the woman and her baby.

The humanization of birth favors the natural development of the mother-child relationship in the first minutes of life, resulting in strengthening their ties, allowing an intense relationship after birth and reducing long-term emotional damage will be. This first contact advocated by the Ministry of Health as one of humanization to remain in the memory of both, which may often occur with harmony, peace and quiet.<sup>6</sup>

Teenage pregnancy can be considered as an event whose meaning varies according to context and historical time in which it is experienced, whereas often the experience of adolescent childbirth is critical, especially for the feeling of intense pain, although for some has been a challenge.<sup>7</sup>

Teenage pregnancy can be considered the same, a period of great vulnerability, and delivery time of this life cycle is seen as a critical moment, marked by a series of significant physical and emotional changes, and involving many levels of symbolism related to fears they feel: the pain of labor and its no-resistance to this pain, the fear of dying, or the baby may die, or be born with this malformation.

In this scenario humanization of labor is of paramount importance for the promotion of physical and emotional factors of women in relation to teenage pregnancy, since these generally face great difficulties as it is a very big change in the life of a teenager before the family the company and partner in this period.

Given the above, the study aims to answer the following objectives: 1) identify the perceptions of adolescents in relation to care provided at the time of labor and delivery, 2) discuss these perceptions with human assistance in labor and delivery.

## METHOD

It is a descriptive, exploratory study, with a qualitative approach, conducted in the rooming of the Maternity Hospital Oswaldo de Nazareth, located in the Rio de Janeiro City.

The investigation was carried out after authorization and approval of the Research Ethics Committee, of the Municipal Secretariat of Health and Civil Defense of Rio de Janeiro, and was approved as also predicts Resolution No. 466/12 of the National Health Council (CNS), in the opinion No. 223/11.

Survey participants were fifteen (15) Teenage pregnancies said housing assembly that met the following inclusion criteria: 1) postpartum women aged between 10-17 years, 2) low risk childbirth, no pathological changes; 3) agree to participate in the search.

The techniques used as a tool for data collection were individual semi-structured interviews, free observation recorded in a field diary, which was held ceased when saturation of testimonials.<sup>7</sup> Data collection took place during the months of March to May 2012. Respondents were identified as "Respondents", and received a sequential alpha-numeric code (E1, ..., E15) to ensure confidentiality and anonymity of their evidence, that

those responsible for adolescent women signed the Informed Consent (IC) conditioned on their participation and ensuring anonymity and confidentiality of information.

For the analysis of the information collected, we proceeded first to the transcription of the interviews recorded on a digital device in full. In this data collection, we used content analysis, in the form of thematic analysis.<sup>7</sup> Thus, the categories and found the results to be discussed were: The service team of obstetric health, the companion: right won; established obstetric practices.

## RESULTS AND DISCUSSION

### Characterization of the subjects

Of the study participants, there was a predominance of women aged between 10-16 years old; the high number of births mainly at an early age makes evident the vulnerability of adolescents to health problems in sexual and reproductive health. As for ethnicity, there was identified a prevalence of 37,5% white adolescents, 25% mulatto and 37,5% black, with no indigenous. Thus we can see that summed the number of black and brown will have 62,5%, thus showing a majority of "non-white" women. The socioeconomic data indicate that the majority of black, are below the poverty line, and so their illiteracy rate is twice the white, they have less access to quality health services and have higher risk of complications during pregnancy and parturition.<sup>8</sup> These data were found separately in a study, which showed a predominance of white teenagers.<sup>9</sup>

Regarding education, 50 % of adolescents had incomplete primary education, 37,5% had not completed high school, and only 12,5 % have completed high school. Complete primary education or higher education completed; postpartum women being illiterate not identified, demonstrating that the majority of respondents have less than 7 years of study and is considered a low level of education.

While gestational age at labor/parturition, 12,5% of women were less than 36 weeks, 12,5% were between 37 and 38 weeks, 62,5% were between 39 and 40 weeks and still 12,5% was over 40 weeks. The fact that adolescents are able to procreate and face the difficulties of childbirth and premature birth of the child at this age underlies a sense of fulfillment and happiness; finding that teen mothers, mostly, are made by feelings of sadness and pain before the health problems presented by the babies, and thus regret their immaturity, for which they can be identified as a threat to their life.<sup>10</sup> Thus we see that gestational age and birth preterm infants influences this relationship that is already so difficult, due to adolescence.

As for the number of pregnancies identified that 100% of respondents were primiparous, or were in their first pregnancy. Adolescents who identify losses caused by early motherhood, so that beyond them do not feel ready to have their first child, contact with the new reality is impacting occur. Since we had no prior commitment and now have several, which interfere with the development of their lives.<sup>11</sup> All parturitions by obstetricians were performed in which a hegemonic class medical care without the insertion

of the obstetric nurse in the scenario of work and childbirth. This fact becomes relevant legitimization of the obstetric nursing; wherein in the nursing profession is in charge assistance dystocia birth process without being bound by Law nº 7.498/86.

For duration of labor of those postpartum women, 25% occurred in up to 5 hours, 62,5 % lasted 5-10 hours, 12,5 % was over 10 hours. It is important to remember that the longer it takes, the more it will last the anguish of these patients, due to being such a delicate and painful situation. Many adolescents report this moment as a painful expectation. To feel her first contractions patients always report a mixture of fear and happiness.<sup>12</sup>

Remember that before so many anxieties of adolescent health team up to try to make this the least possible time prolonged, with humane techniques of pain relief and relaxation of the perineum.

### The care of the obstetric health team

Initially, there is the perception of the mothers on the care received by obstetric staff during your labor and delivery, and also the importance of the health care team for the process, as the testimonials below:

*The tour was very good. The doctor and nurses were very attentive to me during labor (...) I thought it would be different (...) not that the way it was. They were very attentive, helped me. (E1)*

*Take long. I do not think I was not well attended. Everyone was complaining down there (at the reception of 1st floor). That's why I did not have much expansion not, and also had little nurse had neither. (E2)*

*Was well attended, why I did not scream, nor suffered. Only suffered from 8 and 09 dilatation. Most went to the parturition room (...) I was well attended because the doctor was very patient. He helped me a lot. (E6)*

The Program for Humanization of Prenatal and Birth, featuring one of the fundamental aspects of humanization, it is the duty of health units receive with dignity the woman, her family and newborn. This requires ethical and caring attitudes of health professionals and the organization of the institution to create a welcoming environment and establish hospital routines that break with the traditional isolation imposed to women.<sup>13</sup>

In this sense, public women's reproductive health policies must prevail, and the role of the pregnant woman in parturition process, protecting its autonomy and rights. Thus, it is essential a warm and skilled care, leaving the users of the service more satisfied as the quality offered.

Some adolescents indicated satisfaction of care, but there was a small amount which showed dissatisfaction with the care of the professional, which often ends up interfering with the process of care because having a proper quantitative professionals, these help to the whole process of labor and delivery was less painful and time consuming.

The stories of women in the quest for health services express discrimination, frustrations and rights violations and appear as a source of tension and psychic-physical malaise.<sup>8</sup>

Due to these factors we remember that humanization and quality of care are linked to the promotion, recognition, and respect for human rights of the mothers, within an ethical framework to ensure the overall health and well-being.

Since the focus of this study is the perception of adolescents in relation to assistance received, we highlight the main question about how she was treated in the health care team during your labor and delivery, as the testimonials section below:

*As mine was a normal delivery, for me I think it went well. It was as I can tell ... Well correct ... I thought it would be different, and not like the way it was. Were (obstetric team) and attentive. Helped me. The doctor and nurses were very attentive to me during labor. (E11)*

*I enjoyed the tour ... It was very good. They violate well, are attentive. Borrowing (obstetric team) to stay calm ... Helped me a lot. It was good too, each time a doctor came, asking if I was okay, or if not was. (E9)*

*Were very patient with me. I was very nervous and they tried to calm me down, leaving me quiet. (E7)*

Testimonials and before it comes to the assistance offered, it is noticed that for women, fast delivery, good treatment of staff, the little suffering and good condition of the mother and baby were the most important aspects in the positive view of childbirth. Moreover, the presence of the companion is another factor that contributes to the satisfaction of women.<sup>14</sup>

It was noticed that often observed better satisfaction with childbirth in primiparous women, women who are at first birth, which in this study demonstrate the total interviewed, and may have interfered with reports of good service.

The relationship of women to the team of health professionals is considered one of the factors that most affect the memory of the same in relation to the experience of labor and birth, having great importance to your satisfaction.<sup>15</sup>

Therefore, it is perceived that women value professionals who are responsive to questions and acknowledge their needs.

Still see that the quality of that care often ends up, depending more health team than the institution itself, as to account for this process of humanization in obstetric care is necessary to have health professionals humanized. These professionals must be able to understand the subjective dimensions of the patient as a priority.

But, on the other hand, the testimony of some teens, even on the care of the obstetric staff during your labor and birth, was cleared of the same perception about their actions and reactions, trying to be controlled by them to get the assistance appropriate. Consider the following statements below:

*I stood quietly, not screaming. People who complain are not well attended because they shout loud. (E5)*

*Was well attended, because I did not scream. (E6)*

It is of great importance that assistance be careful and affectionate for satisfaction with childbirth. For that professionals should be more attentive, patient, informative, affective, and do not issue opinions on the life and behavior of patients.<sup>15</sup>

Thus one can identify the violence of four professional modes: Overlook; verbal violence, through rough treatment, threat reprimands, cries and intentional humiliation, physical violence by non-use of analgesics when indicated technically, and sexual abuse.<sup>16</sup>

Women consider the information, support and compassion elements needed to feel well cared.<sup>15</sup> Thus, we see how this service affects women in their mode of action, causing them not demonstrate what he wanted at that moment and felt "trapped" in their attitudes to achieve bargain quality care that should occur for all; realized in this way, which is often rooted in the culture of society, putting the health professional as the holder of knowledge, and that they, if the mothers do not have the right to demonstrate.

But the humanization is developing to change this myth. For the moment of birth the woman is the protagonist of the parturition, which should have the freedom to express themselves and do what you want, to make it better moment for her and her son. Not the healthcare team should sort it how. The team should have the role of helping this woman when she wants and needs

In the following reports demonstrate ignorance of women about the time of labor and delivery:

*I thought it would be different, not like the way it was. (E 1)*

*Most did not expect to feel so much pain. (E3)*

*Agent is kind of like; do not know what will happen. (E6)*

In their study<sup>15</sup> found that only 23% of women feel fully informed about what happens to them and the baby during delivery. Thus women evaluated the information received as insufficient. This demonstrates the lack of dialogue and relationship health professional with the woman, and disregarding their rights in their sexual and reproductive issues.

It is important to remember that the more complete and sufficient information received by most women will be reported to the delivery care satisfaction because it allows their involvement in the care process, and helps in making the woman's decision.

The degree of information during labor has been shown to be important for women facts, by allowing greater participation in decision making and increase their perception of who is in control of the situation, which will increase satisfaction with childbirth.<sup>15,17</sup>

Given the statements of the interviewees, which first showed fear and apprehension as to what would happen, and then do not know how it was reporting and what happened. And all this should be a woman's decision because at birth she must realize that you are in control and not the health team will do whatever.<sup>15</sup> Since when this relationship is established properly, the woman feels much safer. Then, information and informed, in health care, women's rights are decision should be promoted.<sup>18</sup>

But some statements the interviewees express, not quite directly, inadequate obstetric care by members of staff:

*The team that was born in his duty was well attended. (E14)*

*I do not know (...) there are people who treat them well, there are people who mistreats (...) There's always one that is evil. (E11)*

Humanization and quality of health care are essential conditions for there to solve the problems identified, to the satisfaction of the users, in strengthening the capacity of women to identify their front demandas.<sup>8</sup> With this, we realize that women view as a quality care and good care when they are assisted by caring, affectionate and caring professionals, which does not always happen in a full team of health.

These reports demonstrate, mostly, in the opinion of the targeted postpartum care were the same quality as the teenagers are unaware of the criteria of humanization.

We understand the attention given to women by the obstetric team, but we also realize that it still stands as having the process stagnating returns on women's empowerment issues in your body, in this case about labor and birth.

### **The companion: a right won**

According to the humanization of labor and birth, to improve the care provided to adolescents, there are several criteria to make humanized and, at this point, the testimony brought questions about the participation of the companion in the whole process of labor and birth.

*I had a companion yes, it was my mother. (E1)*

*I was my mother! (E8)*

*Come to come, could not get over (...) I could not, my grandmother wanted, most have left. (E13)*

The right escort the pregnant woman is guaranteed by the Law n° 11.108/05 and often does not happen in hospitals and public hospitals. The Law guarantees to mothers the right to the presence of a companion during labor, delivery and immediate postpartum, within the Unified Health System (SUS). This law was signed during the II International Congress on Humanizing Birth, in Rio de Janeiro.

The presence of a companion, during labor and childbirth brings many benefits such as shortening the duration of labor, since the companion's role is to assist and encourage this process. In addition to positively influence the training of family bonding, especially if this is the companion father.<sup>14</sup> It is also important to note that this law guarantees the entry of the companion does not arise as exclusionary to the same sex.

Also pointed out that the fact of being a teenager, in the case of these postpartum women, Institution of Health has the right/obligation to permit the monitoring of these adolescents, since Article 12 of Law 8069 of July 13<sup>th</sup>, 1990 that provides for the Statute of children's and other provisions and states that: the health care establishments should provide conditions for full time residence of a parent or guardian, in case of hospitalization of children or adolescents.



In Maternity Hospital where the study was conducted is the presence of a companion set, but is only allowed female, and this is not recommended by the Ministry of Health.

### Established obstetric practices

To increase the degree of reliability of the information provided by the interviewees, yet understanding the possible misrepresentation of information received assistance due to lack of knowledge/understanding of the same in relation to specific health actions. We use the evidence in the medical records of pregnant women on the assistance provided by the obstetric team and supposedly documented through reviews/developments noted in the form.

But sadly realize that the care that should be recorded, for example, how the bidding/stimulating bath, drinking fluids, completion of the enema and venous access with identification of substances administered were not described in their records, verify the impossible reality share obstetric staff in relation to the testimony of the mothers.

Then as to the offering and / or stimulus, obstetrics team to the bath to pregnant women in labor following the statements below:

*I wanted to shower, but a doctor there who was walking (...) did not want to get the serum that I was taking. And after a long time I was showering. (E7)*

*No, because I could not make much effort. Why did they want the baby would hold until Saturday? (E11)*

The shower or soaking with warm water can be used at the beginning of the active phase of labor, when contractions begin to intensify, aiming relaxation and pain relief.<sup>19</sup> realized that was not offered and/or stimulated, as well as denied by the obstetrics team bath pregnant women in labor.

It is recommended in hospitals managed by the NHS to be supported and/or encouraged to pregnant women in labor's bath, so that the same, besides feeling refreshed, relax and move.

This humanized care, which is also characterized by physical comfort measures, causes labor to be faster, because the mother feels more forces and the facilitating of the gravity while standing, and walking itself, which stimulate the descent of the baby and increased dilation in so doing, that this period occurs in less time and less pain for these women.

As for the offering, the obstetrics team of water for pregnant women in labor following the statements below:

*They gave me water to drink (...) put in my mouth, which was very dry. (E2)*

*Only a few drops of water that the nurse put in my mouth. (E5)*

*I could not drink water or eat anything. (E8)*

*It could! (E6)*

To the extent that the approximation of the active phase of labor must be allowed to occur with ingestion of small amounts of liquids such as water, juice, without pulp, tea, coffee.<sup>20</sup>

The model of midwifery care is necessary to have an individualized support during labor and delivery, and is also characterized by measures of physical comfort for pregnant women, which include bath, massages and fluid intake.<sup>21</sup>

So although rarely adolescents report that yes, he was offered the intake of fluids, mostly the answer was negative. And who positioned themselves positively, often just wet mouth to lure the headquarters.

In this light we noticed that despite being standardized by the Ministry of Health to fluid intake by pregnant women during labor/delivery, precisely because the studies proving that it is not contraindicated, is not yet an established practice in health units and obstetric teams.

Regarding performance of the enema or colonic Obstetric Team, pregnant women in labor reported:

*Did washing when I was in the room. (E4)*

*Not needed, I think. (E6)*

*Only did when I was having my baby. (E7)*

The routine use of enema is one of the practices that should be eliminated routines. For the realization of enema is clearly harmful or ineffective, apart from causing nuisance for women.<sup>21</sup>

But you realize that motherhood is not flocking enema as common practice obstetrics, one of the interviewees reported having done, which contradicts with the other. Because it contains no medical records about this practice, we could not identify whether it was actually accomplished.

We understand that the fact the enema really cannot be done at the time of labor is a gain for women and the process of humanization of labor and birth due to lack of exposure of the same, the unnecessary and embarrassing practices that supposedly contribute nothing for that moment.

Regarding the use of venous access for the administration of oxytocin, the obstetric team to pregnant women during labor and childbirth follow the statements below:

*Put the serum to increase to my contraction. (E11)*

*The nurse placed the serum, and soon began to feel the pain, too much pain! (E2)*

The correction of uterine activity with use of oxytocin is considered bad practice often used in normal birth. Oxytocin is able to start or increase the rhythmic contractions at any time during pregnancy, although the uterine response is greater, the closer the end of pregnancy. Intravenous infusion of synthetic oxytocin has been the most used method for induction and conduction of labor.<sup>21,3</sup>

Adverse effects of oxytocin can produce tachysystole, hypertension and uterine hyperstimulation, which can cause including uterine rupture. For the fetus, the most

frequent side effect is acute fetal distress, caused by reduced blood perfusion tachysystole and/or stiffness.<sup>21</sup>

Clearly perceive the statements the association of venous access with the fact feel more pain for the birth process, thus characterizing this two-way relationship.

This induction with oxytocin is harmful to women, since it is often unnecessary and may cause impairments in addition to the fetus, maternal complications, the most common being the intensification of pain arising from uterine contractions aiming faster expansion.

Some teens in labor identified the use of venous access, but not correlated with the administration of oxytocin, also knowing not identify which substances:

*I think whey left with nothing. (E7)*

*I do not know why I also had an antibiotic. (E8)*

In the case of no information about the procedures in the bodies of women/ mothers, due to often, adolescents are unaware about what was accomplished. We realize that various types of interaction between the professional and the patient may occur.

Among these types are non- information that often is one that is not given the purposeful, conscious, thinking that the other will not be able to understand what would be explained.<sup>22</sup>

While humanization and women's empowerment in relation to your body, and therefore your labor and delivery, the obstetric team would have the obligation to inform her about the need for venous access, and about which substances and for the same reason the situation.

Thus, with this type of intervention, the protagonist of the process of giving birth would be the obstetric team, holder of the power, which a woman should "obey" and not question.

Still, as the episiotomy, the professional midwife, the pregnant women in labor and birth following testimony:

*Made on me when I was earning my baby. (E4)*

*They did, yes! And took point. (E14)*

The incision in the perineum is used to increase vaginal canal and has been a widely used practice. However it is a conduit often used inappropriately. Moreover, the liberal use of episiotomy is associated with higher rates of perineal trauma and the lowest rate of women with an intact perineum.<sup>21</sup>

The World Health Organization estimates that in situations like you calculate: in distress, inadequate progress of labor and the threat of third-degree tear, may be good reasons for the indication of episiotomy in childbirth normal evolution.<sup>20</sup>

There is no justification for routine episiotomies, because it is not beneficial for the mother or for the baby, the need for sutures in the perineum and risk of complications in the seventh day after birth, bringing unnecessary pain and discomfort that often may be associated with puerperal infection.<sup>23</sup>

Still, a report of a woman refers to non-episiotomy, but the laceration in the speech below:

*It was he (the newborn) who opened me was not the court did not (...) The doctor said: I did not cut anything, he was born great. (E6)*

The restricted use of episiotomy is associated with a lower risk of posterior perineal trauma, need for suturing and healing complications, it is concluded that in practice, the restricted use appears to be beneficial when compared to routine episiotomy.<sup>23</sup>

The interviewee says that indicates the humanization because episiotomy but the protection of the perineum to avoid laceration was not performed. But it was not enough, because the baby was great and it was a torn perineal tissue and need for suturing in the case, thus setting up an episiorrhaphy.

Yet another postpartum refers to not knowing about the procedures performed on his body at birth:

*Guess that underwent episiotomy, because I took point. (E8)*

This difficulty of information procedures in the bodies of women/mothers, once again identifies a continuous and silent process of objectification of users of health services, which reduces the person to a body without a body.<sup>23</sup>

Thus, the health professional creates a fragmentation mode the person to see. This often does not know what the professionals speak while performing procedures on their bodies.

So, once again, there is a clear lack of information of the obstetric staff regarding the procedures performed in the parturient body, where it says find that episiotomy was performed by correlation have noticed the action of the suture, but not be aware of fact. It is worth noting that those procedures were recorded in medical records.

## CONCLUSION

In this study it was possible to see the walk of obstetric care during labor and birth. We saw that first deliveries were conducted by midwives and home, where the woman was the star of the moment, but this parturition panel turned sharply and began to deploy and implement the hospitalization of the birth process with advances in technology.

Currently we see a great effort for the delivery back to their place of origin, where the woman is able to make their own decisions on how to give birth, and that assistance is more humanized.

Before the study we seek to understand their perception on the assistance they received at the time of labor/birth and understand that the majority believes she received good care, more appropriate care at that moment, since culturally the company is not aware of how labor and delivery can be humanized and less medicalized.

But, despite the perception of the mothers on proper care at the time of labor and birth, it is contradicted by the data collected, since most often occurred unnecessary interventions that are not recommended by the Ministry of Health

Still see a health care gap during the survey period in said Municipal Maternity, where the midwives, who should be acting in the obstetric ward, watching the woman at

the normal delivery due to lack of nurses, would be acting in other sectors and leaving space for only obstetricians performed this activity.

Also identify gaps as to the records made by health professionals in the medical records on labor and birth, as we need to confirm some information collected postpartum women about this point, but that was not possible due to missing data in those documents.

Therefore, realize the great difficulty encountered by municipal Maternity to implement a humanized assistance to women during labor/birth, especially with her teenage self as the phase goes through a difficult period and with so many changes.

Therefore, it is concluded that the implementation and awareness of health professionals for a humanized form part of the main strategy to change this scenario. This can occur through empowerment and training of health professionals, understanding that humanization should be connected with the promotion, recognition and respect to these teenagers.

Because for the realization of all these efforts are necessary strategies together professionals providing care, the hospital and the Ministry of Health Since, humanization and quality of health care, are essential conditions for there to solve the problems identified, to the satisfaction of the users, in strengthening the capacity of women to identify forward their demands.

## REFERENCES

1. Vieira SM, Bock LF, Zocche DA, Pessota CU. Percepção das puérperas sobre assistência prestada pela equipe de saúde no pré-natal. *Texto & contexto enferm.* 2011; 20(spe):255-262.
2. Longo CSM, Andraus LMS, Barbosa MA. Participação do acompanhante na humanização do parto e sua relação com a equipe de saúde. *Rev. eletrônica enferm.* 2010; 12(2):386-391.
3. Barros SMO. *Enfermagem obstétrica e ginecológica: guia para a prática assistencial.* 2º ed. São Paulo (SP): Roca; 2009.
4. Moura FMSSP, Crizostomo CD, Nery IS, Medonça RCM, Araújo OD, Rocha SS. Humanization and nursing assistance to normal childbirth. *Rev. bras. enferm.* 2007; 60(4):452-455.
5. Malheiros PA, Alves VH, Rangel TSA, Vargens OMC. Labor and birth: knowledge and humanized practices. *Texto & contexto enferm.* 2012; 21(2):329-337.
6. Ministério da Saúde (Br). *Atenção humanizada ao recém-nascido de baixo peso: Método Canguru.* Brasília; 2011 [citado 2012 Novembro 12]. Disponível em: URL: <http://abenfo.redesindical.com.br/arqs/manuais/020.pdf>
7. Minayo MCS. *Pesquisa social: teoria, método e criatividade.* 28ª ed. Rio de Janeiro (RJ): Vozes; 2010
8. Ministério da Saúde (Br). *Política nacional de atenção integral a saúde da mulher: princípios e diretrizes.* Brasília; 2011 [citado 2012 Novembro 12]. Disponível em: URL: [http://bvsmis.saude.gov.br/bvs/publicacoes/politica\\_nacional\\_mulher\\_principios\\_diretrizes.pdf](http://bvsmis.saude.gov.br/bvs/publicacoes/politica_nacional_mulher_principios_diretrizes.pdf)
9. Filho FP, Sigrist RMS, Souza LL, Mateus DC, Rassam E. Perfil epidemiológico da grávida adolescente no município de Jundiá e sua evolução em trinta anos. *Adolesc. saude.* 2011; 8(1):21-27.
10. Chagas NR, Monteiro ARM. A relação entre mãe adolescente e o bebê pré-termo: sentimentos desvelados. *Rev. gaúch. enferm.* 2007; 28(1):35-44.
11. Kong AB, Fonscall AD, Gomes VLO. Representações sociais de adolescentes primíparas sobre “ser mãe”. *Rev. eletr. enf. [periódico on line]* 2008; [citado 24 nov 2012] 10(2): [aprox. 9 telas]. Disponível em: <http://www.revistas.ufg.br/index.php/fen/article/view/8042/5819>
12. McCallum C, Reis AP. Re-significando a dor e superando a solidão: experiências do parto entre adolescentes de classes populares atendidas em uma maternidade pública de Salvador, Bahia, Brasil. *Cad. saúde pública.* 2006; 22(7): 1482-1491.
13. Carvalho VF, Kerber NPC, Busanello J, Gonçalves BG, Rodrigues EF, Azambuja EP. Como trabalhadores de um centro obstétrico justificam a utilização de práticas prejudiciais ao parto normal. *Rev. Esc enferm USP.* 2012; 46(1): 30-37.
14. Longo CSM, Andraus LMS, Barbosa MA. Participação do acompanhante na humanização do parto e sua relação com a equipe de saúde. *Rev. eletr. enf. [periódico on line]* 2010;

[citado 24 nov 2012] 12(2): [aprox. 6 telas]. Disponível em: <http://www.fen.ufg.br/revista/v12/n2/pdf/v12n2a25.pdf>

15. Domingues RRS, Santos EM, Leal MC. Aspectos de satisfação das mulheres com a assistência ao parto: contribuição para o debate. *Cad. Saúde Pública*. 2004; 20(supl1):552-562.

16. Aguiar JM, D'Oliveira AFPL. Violência institucional em maternidades públicas sob a ótica das usuárias. *Interface comun. Saúde educ*. 2011; 15(36):79-92.

17. Tedesco RP, Filho NLM, Mathias L, Poli JL, Lacerda AA, Coradelli ACP, *et al.* Conhecimento e expectativas de gestantes acerca da indução do parto. *Perspect médicas*. 2011; 22(1):20-25.

18. Sodré TM, Bonadio IC, Jesus MCP, Merighi MAB. Necessidade de cuidado e desejo de participação no parto de gestantes residentes em Londrina-Paraná. *Texto & contexto enferm*. 2010; 19(3):452-460.

19. Gallo RBS, Santana LS, Marcolin AC, Duarte G, Quintana SM. Recursos não-farmacológicos no trabalho de parto: protocolo assistencial. *FEMINA*. 2011; 39(1):41-48.

20. Ministério da Saúde (Br). Protocolo municipal de atenção ao pré-natal e puerpério: nascer colombo. Paraná; 2012 [citado 2012 Novembro 12]. Disponível em: URL: [http://www.colombo.pr.gov.br/downloads/saude/062012/5-PROTOCOLOMUNICIPAL-DE-ASSIT\\_NCIA-AO-PRE-NATAL-2012.PDF](http://www.colombo.pr.gov.br/downloads/saude/062012/5-PROTOCOLOMUNICIPAL-DE-ASSIT_NCIA-AO-PRE-NATAL-2012.PDF)

21. Ministério da Saúde (Br). O modelo de atenção obstétrica no setor de saúde suplementar no Brasil: cenários e perspectivas. Brasília; 2008 [citado 2012 Novembro 12]. Disponível em: [http://www.ans.gov.br/portal/upload/noticias/clipping/livro\\_parto\\_web.pdf](http://www.ans.gov.br/portal/upload/noticias/clipping/livro_parto_web.pdf)

22. Ferreira ABH. Dicionário Aurélio de língua portuguesa. 5ª ed. Rio de Janeiro (RJ): Editora Positivo; 2011.

23. Diniz SG, Chacham AS. O “corte por cima e o corte por baixo”: o abuso de cesáreas e episiotomia em São Paulo. *Questão de Saúde Reprod*. 2006; 1(1):80-91.

Received on: 14/08/2013  
Required for review: No  
Approved on: 06/01/2014  
Published on: 01/07/2014

Contact of the corresponding author:  
Diego Pereira Rodrigues  
Rua Desembargador Leopoldo Muylaert n. 307, Piratininga, Niterói,  
Rio de Janeiro, CEP: 24350-450. Email: [enf.diego.2012@gmail.com](mailto:enf.diego.2012@gmail.com)