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CHARACTERIZATION OF PREGNANCY LABOR ASSISTANCE OF PRIMIGRAVIDA ADOLESCENTS IN THE CITY OF CUIABÁ-MT[1]

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ABSTRACT
It aimed to analyze labor assistance for primigravida adolescents in the context of the Unified Health System (SUS) in the city of Cuiabá, Mato Grosso. Cross-sectional, descriptive and documental study with a random sample composed of 164 medical records of postpartum adolescent collected through structured file during the months of December 2012 to May 2013. Data were analyzed through simple descriptive analysis. The results indicated that cesarean section showed rate of 37.2%, amniotomy was adopted in 62.1%, oxytocin 53.4% and 82.4% in the episiotomy. Cephalopelvic disproportion represented 27.9% of cesarean section indications and among maternal complications, hemorrhage stood out in both types of delivery. It is concluded that there is a strong influence of the technicist model on maternal outcomes in obstetric care to pregnant adolescents and that the lack of knowledge linked to the vulnerability of this group shows the professional sovereignty in relation to obstetric decisions.

Keywords: Humanizing delivery. Obstetric nursing. Women's health.

INTRODUCTION

Childbirth is characterized as a single event and outlined by a mixture of feelings that means a very significant event in the mother´s life and her family. At any age, women experience this process in a unique way in which changes in physical, psychological, emotional and social fields transform their world view and their social relations. In adolescence, these changes represent an even greater impact because they are involed with hormonal changes, not planned pregnancy and weary marital and family relationships, rising the emerging need for skilled care[1].

In this sense, the Ministry of Health has sought to carry out extensive work of consciousness, meditation and changes in attitudes of health professionals regarding the humanization of care and management under the Unified Health System (SUS) after creating in 2003 the National Humanization Policy (NHP). As for the process of pregnancy, childbirth and postpartum, the humanization movement has been strenghtened through the launch of the Program for Humanization of Birth and Labor (PHPN) in 2000 and the Stork Network in 2011 that aims to qualify the care networks and reduce the high maternal and infant mortality rates in the country[2].

However, it is evident in our country the prevalence of a childbirth care model with excessive interventions such as the use of oxytocics and conducting amniotomies, episiotomies, Kristelere caesareans maneuver, which high rates show the indiscriminate and routinely way that are performed in hospitals in the country[3]. Such practices reflect the greatly increased maternal and newborn morbidity and mortality rates[4]. An important indicator of technicist care model are the high Cesarean birth rates recorded in 2013 the proportion of 56.6% of total births among the public and private Brazilian institutions[5].

The cascade of interventions not based on scientific evidence made during the mother´s hospitalization process reflects the lack of commitment and responsibility of professionals for the care already started in the prenatal. In this initial phase, women are not informed about the benefits of vaginal delivery, appropriate

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obstetric care and good practices of delivery care and birth recommended by the World Health Organization (WHO)[6]. Such practices include the right to choose woman on her companion, delivery place privacy, fluid intake during labor and delivery, use of partogram, non invasive method and non-pharmacological pain relief, among others.

Discussions about obstetric care held in Brazil reveal a reality guided by the interference of the birth process, without sufficient scientific evidence to justify it[7] and regarding to pregnant adolescents it is important to note that, due to the specificities of the age group, it is necessary a differentiated assistance for both prenatal and for birth and postpartum.

This way, health professionals must recognize the birth uniqueness of a teenager and have the sensitivity to exercise obstetric care safely, with skill and respect, because these young women experience diferente and disruptive feelings throughout the pregnancy, especially along pregnancy and postpartum process. What is observed in reality is little or no specificity in the care given to adolescent woman in labor[8].The speech that vaginal birth is harmful, especially when it comes to pregnant adolescents, is a speech that conveys among health professionals and extends among pregnant women and their families.

This way, this study aimed to analyze the care delivered to pregnant adolescents in the context of the Unified Health System (SUS) in the city of Cuiabá, Mato Grosso. The relevance of this study is justified by analyzing if the delivery care held in this city is consistent with the perspective of the birth humanization and in what actions obstetrical practices support or not the natural evolution of childbirth, having as indicator the maternal health conditions.

METHODOLOGY

Cross-sectional, descriptive study, with simple random sampling without replacement analyzed from documents in records. The study sites were three hospitals responsable for 95% of deliveries financed by SUS in the city of Cuiabá, MT. The study took place from December 2012 to May 2013.

It was used a representative sample of a population of 839 women aged less than or equal to 19 years old, first pregnancy, which resulted in the child's pregnancy born alive in the three selected hospitals[9], adopting a confidence interval of 95 % and a sampling error of 5% up to the value of 164 adolescents to be researched. The inclusion criteria for the sample results - adolescent women, first pregnancy and prenatal care done at Family Health Care Strategy Units in the study city. Were excluded incomplete records with illegible writing and without the data recorded on the partogram. Primiparity as one of the inclusion criteria in the study was justified to reduce the elements that could behave as confusion factors in the data analysis, once the evolution of labor in multigravida and multiparous is more briefly[4]. The choice of postpartum adolescent mothers was to homogenize the anatomical and physiological characteristics of the first pregnancy group.

Initially, the filing sectors of hospitals have provided the required medical records for verification and at that time were applied the criteria for inclusion and exclusion of the research so it was obtained the sample of 164 records. Later, data collection started through a previously prepared a standardized form containing topics related to mother characteristics (age, race/color, education, marital status, occupation) and delivery characteristics (type of delivery, cesarean indication, cervical dilation, state of amniotic membranes at the time of admission, type of rupture of membranes, use of oxytocin, episiotomy with and without laceration, duration expulsive period of labor, birth evolution and complications/intercurrencein childbirth and postpartum).

To assess the evolution of births was considered eutocic delivery, one whose expected expansion rate for women entering the active phase of labor, reached 1.2 cm/hr in nulliparous. Thus, it was considered eutocic those delivery dilatation average ranging from 0.8 to 1.3 cm/hr and dystocic the delivery which the dilation occurred less than 0.8 cm/hr[10]. Regarding delimitation of latent and active phases of labor were accepted the hospitalizations that occurred up to 3cm dilation for latent phase and greater than 3 cm to the active phase[10].

Epi-Info software version 3.5.2 for database and statistical analysis was used. Double data entry was done and later the Epi-Info was applied - date compare to correct typographical errors. For data analysis was used simple descriptive statistics. The distribution of the data was presented using absolute and relative frequency.

Research was submitted to the Ethics Committee at the University Hospital Júlio Müller, CNS Resolution 466/2012 obtaining approval for its development through the opinion 112,146.

RESULTS AND DISCUSSION

Out of 164 adolescents studied, it was found that their ages were between 13 and 19 years, mean 16.8 years with a high proportion of Brown race/color (79.8%). Regarding education, 60.3% had eight or more years of study, and most were married or in a stable relationship (71.9%), and did not have a job (95.1%).

Table 1 shows the characteristics of pregnant adolescentes in the moment of hospitalization, according to the route of birth in the contexto of births done by SUS.

Table 1. Obstetric characteristics of pregnant adolescents according to type of delivery, Cuiabá, 2012-2013.

Variables	Type of delivery		
	Vaginal (n=103)	Cesarean (n=61)	Total (n=164)
	n (%)	n (%)	N
Cervical dilation at hospital admission*			
<3 cm	14 (32,6)	29 (67,4)	43
≥3 cm	89 (76,0)	28 (24,0)	117
Not informed	0 (00,0)	4(100,0)	4
Amniotic membrane at the time of hospital admission*			
Ruptured	39 (78,0)	11 (22,0)	50
Intact	64 (60,4)	42 (39,6)	106
Not informed	0 (00,0)	8(100,0)	8
Type of membranes rupture:			
Amniotomy	64 (62,1)	-	64
Timely	54(84,4)	-	54
Premature	01(1,6)	-	01
Delayed	09 (14,0)	-	09
Espontaneous	39 (37,9)	-	39
Ocxytocin use		-	
Yes	55 (53,4)	-	55
Justified	31(56,3)	-	31
Not justified	24 (43,7)	-	24
No	48 (46,6)	-	48
Episiotomy			
Yes	85(82,5)	-	85
With laceration	02 (2,4)	-	02
Without laceration	83 (97,6)	-	83
No	18(17,5)	-	18
With laceration	08 (44,5)	-	08
Without laceration	10 (55,5)		10
Birth evolution		-	
Eutocic	60(58,3)	-	60
Dystocic	43(41,7)	-	43

*4 charts did not have records about cervical dilation at admission and 8 charts did not have information about the integrity of the amniotic membranes.

Considering the obstetric variables, Table 1 shows that 62.8% were vaginal deliveries and the rate of surgical deliveries was 37.2%. It must be considered a high cesarean rate, as World Health Organização (WHO) admits numbers between 10 and 15% and states that cesarean levels greater than 10% are not associated with reduction of maternal and neonatal mortality[6].

The data show that among the 43 adolescents admitted in the latent phase of labor, that is, before cervical dilatation reaches 3 cm, most (67.4%) was submitted to Cesarean delivery. For those who were hospitalized in the active phase of labor, vaginal deliveries (76.0%) were predominant. The benefits of hospitalization after the latent phase are known, except for some clinical situations, because it reduces the time in the pre-delivery room, reduces the possibility of receiving intrapartum oxytocin, minimizes the need for analgesia and points more control during labor[11], favoring vaginal delivery.

Another obstetrical data that interferes with the decision for hospitalizing the woman is the situation of the membranes, which is directly reflected in the actions taken during labor. In this research it was found that amniotomy was one of the most used procedures in the hospital routine to accelerate labor. This fact was observed in most adolescents, whereas in 62.1% artificial rupture of the amniotic membrane was performed. It can be affirmed that this procedure is indicated in the presence of dystocia in the evolution of labor[12]. This method can cause undesirable effects, such as early deceleration of fetal heart rate, changes on the fetal head[13], among others cited in the literature.

In as much as in the amniotomy, the use of oxytocin in the active management of labor should be kept for selected cases and it is not recommended in the regular basis. However, in this study, 53.4% of adolescents used oxytocin, out of these, only 56.4% had their use justified. By analyzing the partograms, it was possible to detect that in 43% of pregnant women it was not founded the real indication of oxytocin. Similar data were found in another study, in which 91.3% of the adolescents received oxytocin infusion and 73.9% had amniotomy delivery care[13].

Study of 655 primiparous assisted in four maternity hospitals in Belo Horizonte, in which three use the traditional model of childbirth care in Brazil characterized by the obstetrician presence and by the hospital care, and one works with the collaborative model of maternity care that means integration of physician and obstetric nurse in the team, identified rates above 50% for both, infusion of oxytocics and amniotomy in both delivery care models, indicating routine use of these interventions[14], which leads us to consider that regardless of age and primiparity, vaginal delivery has been practiced in Brazilian hospital services.

Also regarding the conduits held in childbirth care, episiotomy was observed in 82.5% of adolescents in this study. This practice has been to childbirth with the intention of reducing possible damage due to the natural process of perineum laceration, aiming to reduce risk of subsequent urinary and fecal incontinence, and to protect the neonate birth trauma[3]. It is noteworthy that according to the (WHO) recommendations[6], the constant practice of episiotomy without precise indications does not show benefits, and should selectively occur in about 10 to 15% of cases. Systematic review study concluded that, when compared to routine use, selective episiotomy has a lower rate of rear perineal trauma, the lower necessity of suture and complications during the healing process[15].

Women who perform vaginal delivery are subject to the occurrence of trauma to the perineum resulting from spontaneous episiotomy or lacerations even with the adoption of obstetric care policies based on scientific evidence as recorded in the study that followed 6,365 vaginal deliveries, of which 38.4% had perineal trauma considered serious, including episiotomy and perineal laceration of second or third degree[16]. In this study it was identified that among the 18 adolescents who were not submitted to episiotomy procedure, 44.5% had lacerations of the first and second degrees, and only one had fourth degree laceration associated with the practice of episiotomy. Importantly episiotomy associated with perineal laceration can determine higher maternal morbidity once it reaches muscle tissue favoring the infection process and compromising the clinical outcome with a negative effect on activities of postpartum women[16].

These data lead to the reflection that interventions in the parturition process characterize the hegemonic and technicist model, where

professional authority stands out in the decision-making power of the woman who, due to lack of knowledge of interventional procedures during childbirth, loses autonomy and is excluded from the obstetrical decisions. This condition worsens in the case of teenagers experiencing birth for the first time, because, in most cases, they are not informed about the procedures performed, especially episiotomy[15]. This demonstrates the lack of dialogue and responsibility of health professional with the care given to women, once it ignores their sexual and reproductive rights. Births were classified into eutocic and dystocic. The eutocic birth is one that occurs physiologically, begins spontaneously, progresses and ends without complications or intercurrences, and does not involve interventions besidesthe whole and respectful support. On the other hand, the dystocia is characterized by a failure in progress of labor, that is, when the cervical dilation in the active phase of labor is below the average due to ineficiente uterine contractions or due to an absolute or relative deproportioned cephalopelvic[10]. In this study it was observed that 58.3% of adolescents had an evolution to physiological labor.

Among adolescents who had natural birth, the average duration of the latent phase of labor was 11 hours and 30 minutes, ranging from 8 to 21 hours. The duration of labor in nulliparous women can reach 20 hours and in multiparous women up to 14 hours, if the latent phase exceeds these values, the diagnosis is of prolonged latent period indicating dystocia of preparatory delivery period and therefore induction with drugs such as oxytocin is recommended. However, prolonged latent phase should not be an indication for cesarean section[10].

Table 2 shows the cesarean section indications occurred in the studied adolescents. It was observed that some are related to complications during pregnancy and labor, woman and fetus clinical status, among others.

The cases of cephalopelvic disproportion (CPD) represented 27.9% of cesarean section indications, followed by progression stop (23.0%) and fetal distress (13.1%). Among the obstetrical situations identified in the study, it was found that women with cephalopelvic disproportion indication were submitted in greater proportion to the infusion of oxytocin (62.5%) when compared with other indications.

Table 2. Frequency of cesarean indications in primigravida, Cuiabá, 2012-2013.

Indications	N	%
Cephalopelvic disproportion	17	27,9
Progression stop	14	23,0
Fetal distress	8	13,1
Severe HDP	5	8,2
Failed oxytocininduction	3	4,9
Breech birth	3	4,9
Oligoamnios	3	4,9
Pelvic inflammatory disease	2	3,3
Preterm labor	1	1,6
Premature rupture of membranes	1	1,6
Post-term pregnancy	1	1,6
Severe ascites	1	1,6
False labor	1	1,6
Nothing stated	1	1,6
Total	**61**	**100,0**

Cesarean section, like any surgical procedure, involves risks and is often associated with higher rates of maternal mortality and its benefits to the fetus are small[17]. Thus, it is important to note that performing a cesarean delivery should take place after the delivery test, with precise and rational indication.

Among the cesarean section indications in first pregnancy, cephalopelvic disproportion and breech presentation are associated with increased risk of caesarean section[18]. As the other cesarean section indications, such as premature rupture of membranes, preterm labor, oligohydramnios and HDP, the justification for performing cesarean delivery would be plausible if other factors were contributing to the risk of maternal or fetal life, because such indications correspond to situations that, itself, do not require surgical delivery, and can be corrected and performed vaginally[19]. It is noteworthy that the cesarean demonstrates its importance and usefulness as an appropriate technology in various obstetrical situations that require the interruption to protect the life of the mother or fetus, as long as there is a real and necessary indication.

According to pre-existing problems, the development of gestation or development of labor can cause complications which interfere with maternal and fetal life quality. Hemorrhage constituted a major complication/intercurrence during the stage of labor and postpartum with uniform distribution between the delivery routes, resulting in a more severe case in the cesarean delivery due to realization of hysterectomy due to hypovolemic shock. Observational study found that 27.6% of women had complications in childbirth due to hemorrhagic causes and 16.2% of cases had no apparent etiology and 11.8% were from uterine atony[20].

It is worth noting that the bleeding complications may also occur in vaginal delivery, since it presents various interventions in its course. The use episiotomy is also related to hemorrhage and increases the risk of perineal laceration of third and fourth degrees and risk of infection without reducing the complications related pain, and long-term complicationsas urinary and fecal incontinence[16]. Thus, the technological interventions during labor can cause bleeding among other complications as found in this study.

FINAL CONSIDERATIONS

This study identified the main maternal outcomes of obstetric care provided to primigravida indicating a strong influence of the technicist model. Although the study was conducted in health institutions that are adapting to the humanization of childbirth care, the data show an interference of actions based on interventional medical-supremacy that distanced the humanization proposals.

It is assumed that the lack of knowledge of the adolescentes and their exclusion about obstetrical decisions points some of the features of the current model of childbirth care, making them more vulnerable when compared to adult women, as they generally belong to the poorest social and economic classes, school delays and difficulties accessing prenatal care. In this context is more evident authoritarian imposition by professionals reaffirming its power over the female body. Therefore, professionals should enhance awareness that such practices should not be done on a regular basis and in a mechanized way, trying alternatives that protect the individuality of the woman and put her in the center of the birth process, in order to establish a democratic and effective assistance towards care humanized.

The high rates of interventions in childbirth reveal a setback in relation to the principles of humanized birth, which reaffirms the importance and benefits of normal birth and gives the woman the reestablishment of their confidence, allowing her to become more secure and proactive during childbirth and care for her child.

It is noteworthy that one of the limitations of the study was the collection of data based on records and partograms with the possibility of influence of some factors such as the absence of a protocol for cesarean section indication and the lack of accurate records in partogram that could have a interference in the interpretation of the researcher.

Given the above, it is understood that women subject to the current childbirth care model are increasingly vulnerable and susceptible to risks of iatrogenic in childbirth because the more pregnant women are exposed to interventions in childbirth, more are the chances of adverse effects of this technology. A good birth does not depend on an abusive number of interventions and, according to the principles of humanization of childbirth, is configured in the relations between the subjects of the birth process, allowing the understanding of reality through a multi-dimensional watch that helps to intervene and propose solutions to problems found in the obstetrical care routine.

CHARACTERIZATION OF PREGNANCY LABOR ASSISTANCE OF PRIMIGRAVIDA ADOLESCENTS IN THE CITY OF CUIABÁ-MT

RESUMO

O objetivo foi analisar a assistência ao parto de adolescentes primigestas no contexto do Sistema Único de Saúde (SUS) no município de Cuiabá, Mato Grosso. Estudo transversal, descritivo e documental com amostragem aleatória simples composta por 164 prontuários de puérperas adolescentes coletados por meio de ficha estruturada durante os meses de dezembro de 2012 a maio de 2013. Foi realizada análise descritiva simples dos dados. Os resultados indicaram que o parto cesáreo apresentou taxa de 37,2%, a amniotomia foi adotada em 62,1%, a ocitocina em 53,4% e a episiotomia em 82,4%. Adesproporção céfalo-pélvica representou

27,9% das indicações de cesariana e dentre as complicações maternas, a hemorragia destacou-se em ambos os tipos de parto. Conclui-se a existência de uma forte influência do modelo tecnicista sobre os resultados maternos na assistência obstétrica de adolescentes primigestas e que o fato do desconhecimento atrelado à vulnerabilidade deste grupo populacional evidencia a soberania do profissional em relação às decisões obstétricas.

Palavras-chave: Parto humanizado. Enfermagem obstétrica. Saúde da mulher.

CARACTERIZACIÓN DE LA ATENCIÓN AL PARTO EN ADOLESCENTES PRIMIGESTAS EN EL MUNICIPIO DE CUIABÁ-MT

RESUMEN

El objetivo ha sido analizar la atención al parto de adolescentes primigestas en el contexto del Sistema Único de Salud (SUS) en el municipio de Cuiabá, Mato Grosso. Estudio transversal, descriptivo y documental con muestreo aleatorio simple compuesto de 164 registros médicos de puérperas adolescentes recogidos a través del formulario estructurado durante los meses de diciembre de 2012 hasta mayo de 2013. Fue realizado el análisis descriptivo simple de los datos. Los resultados indicaron que el parto por cesárea ha presentado tasa de 37,2%, la amniotomía fue adoptada en 62,1%, la oxitocina en 53,4% y la episiotomía en 82,4%. La desproporción cefalopélvica ha representado 27,9% de las indicaciones de la cesárea y entre las complicaciones maternas, la hemorragia se ha destacado en ambos tipos de parto. Se concluye que existe una fuerte influencia del modelo técnico sobre los resultados maternos en la atención obstétrica a las adolescentes primigestas y que el hecho del desconocimiento relacionado a la vulnerabilidad de este grupo poblacional evidencia la soberanía del profesional en relación a las decisiones obstétricas.

Palabras clave: Parto humanizado. Enfermería obstétrica. Salud de la mujer.

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