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"The Cut Above" and "the Cut Below": The Abuse of Caesareans and Episiotomy in São Paulo, Brazil

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Abstract: *In the last 50 years, a rapid increase in the use of technology to start, augment, accelerate, regulate and monitor the process of birth has frequently led to the adoption of inadequate, unnecessary and sometimes dangerous interventions. Although research has shown that the least amount of interference compatible with safety is the paradigm to follow, vaginal birth is still being treated as if it carries a high risk to women's health and sexual life in Brazil. This paper describes the impact of the intervention model on women's birth experience, and discusses how the organisation of public and private maternity services in Brazil influences the quality of obstetric care. Brazil is known for high rates of unnecessary caesarean section ("the cut above"), performed in over two-thirds of births in the private sector, where 30% of women give birth. The 94.2% rate of episiotomy ("the cut below") in women who give birth vaginally, affecting the 70% of poor women using the public sector most, receives less attention. A change in the understanding of women's bodies is required before a change in the procedures themselves can be expected. Since 1993, inspired by campaigns against female genital mutilation, a national movement of providers, feminists and consumer groups has been promoting evidence-based care and humanisation of childbirth in Brazil, to reduce unnecessary surgical procedures.* © 2004 Reproductive Health Matters. All rights reserved.

Keywords: evidence-based medicine, caesarean section, episiotomy, medicalisation of childbirth, humanisation of childbirth, Brazil

"If I were a woman I would have started, I don't know, an armed insurrection, because there is too much violence… She goes to the maternity hospital, and either they cut her belly, unnecessarily most of the time, or her perineum. Anyway someone is going to assault her with a knife." (A. Atallah, Brazilian Cochrane Centre)[1]

IN the last 50 years, there has been a rapid increase in the use of technologies whose purpose is to start, augment, accelerate, regulate and monitor the process of birth, all with the aim of making it "more normal" and to improve the outcome for women and infants' health. In this process, both in developed and developing countries, the search for ways to improve the quality of assistance at birthing has frequently led to its medicalisation and an uncritical adoption of inadequate, unnecessary and sometimes dangerous interventions, without proper evaluation of their effectiveness or safety.[2,3]

However, by the end of the century, an international movement had grown that campaigned for medical care based on empirical evidence of safety and effectiveness of medical procedures in all specialities, evidence-based medicine (EBM). In the case of pregnancy and

assistance at birth, practices are used in the course of a process that is usually though not always normal. Scientific evaluation has shown that minimal intervention – the least amount of interference compatible with safety – is the paradigm to follow for a normal birth. Thus, during delivery and birth there must be a valid reason to intervene in a natural process, which is to do entirely with complications in the woman or the infant.[2–4]

The incorporation of these changes in Latin American countries has been very slow and has met great resistance,[5] including from teaching institutions. In most medical schools in Brazil, providers are still taught the intervention model. Surgical ability and sophisticated pathology assistance are highly valued, while comparatively little attention is paid to women-centred care for normal deliveries, and good communication and interaction with all birthing women.[6,7]

This paper describes and discusses the impact on women's health and sexuality of the intervention model on women's birth experience in Brazil, drawing on information from qualitative and quantitative studies in the published literature. Quotes from interviews with doctors, nurses and patients collected in the course of our own studies in this area are also presented. These illustrate how the organisation of maternity services in the public and private sectors influences the quality of obstetric care, leading to high rates of unnecessary caesarean section and episiotomy.

Giving birth in Brazil

In Brazil, 96.5% of births take place in hospitals.[8] This does not indicate that Brazilian women receive good assistance, however. According to the Brazilian Ministry of Health, the maternal mortality ratio in 2002 was 74.8 deaths per 100,000 live births,[9] while the UNDP Development Report 2003 gives a (contested in Brazil) estimate of 260 per 100,000.[10] Most maternal deaths were in women who had had antenatal care. Hypertensive disorders in pregnancy and haemorrhage are the most common causes of death, followed by complications of unsafe abortion.[6]

Inequality is a significant characteristic of health care in Brazil, with social, economic and regional parameters. Brazilian women can be divided into the more affluent 30%, who have some kind of private health insurance, and the poorer 70% who depend on the Brazilian Public Health System (Sistema Único de Saúde, SUS). According to the Brazilian Constitution (1988) access to health care is a universal right and it is a duty of the state to provide it. Both in the public and the private sectors, good and bad standards of care can be found, but substandard care is prevalent. Health Ministry data show that in 2002 only 5% of pregnant women enrolled in antenatal care programmes had received the standard antenatal care services.[11]

Private health services and private health insurance are favoured by anyone who can afford them. Within the diversity of health plans and insurance available, there is normally a group of specified health care providers and hospitals that women must use. The most expensive health insurance gives women the right to choose which doctor will assist her during birth, usually the same one she sees for antenatal care. This continuity of care is highly valued but it is generally not available for women who use the SUS. They will see a doctor for antenatal care at the health centre and will be attended by any doctor who happens to be on duty in the hospital when they arrive, whom they have most likely never before met. Since doctors do not necessarily introduce themselves in these circumstances, women often do not even learn the names of those who assisted them.[6]

The obstetric pilgrimage

Women who use the SUS for antenatal care frequently cannot secure a place in advance where they can deliver. The guidelines for antenatal care instruct public health providers to give women a referral letter to a hospital by the end of pregnancy, to help them to secure a bed when in labour. Providers joke that this is an *alvará de vire-se* (license to look after yourself) because often it does not secure anything.[12] Frequently, their first choice of hospital is full and women have to go looking for a bed on their own, sometimes to more than one hospital. A study in the city of São Paulo in 2002 found that among low-income women, 76% had had to go to more than one hospital during labour to find a bed – 61% went to two institutions and 15% to three or more.[13] For women with high-risk pregnancies, this ''pilgrimage'' to find a

bed can be lethal; in São Paulo, 55% of maternal deaths occurred during or shortly after a woman's search for a bed.[14]

Several public initiatives have taken up this problem in the last decade. In 2000 the Ministry of Health launched the Programme for Humanisation of Childbirth and gave health authorities in several cities incentives to find solutions to this problem. In Belo Horizonte, the third largest city in Brazil, since 2002 each of the nine health districts has its own reference hospital. Women from that district go directly there and if the hospital is full, the hospital has to find a bed elsewhere and take the woman there. Anecdotal evidence indicates that most women, but not all, now find a place or are taken to another hospital. However, women now complain that their choice is limited as they have to go to the local hospital whether they like it or not (Dr Sônia Lansky, Maternal Mortality Committee, Belo Horizonte, personal communication, 2003).

For women who depend on the SUS, access to a bed in any maternity ward presents several problems. One problem is when to go to the hospital to ensure access to a bed. Because there is no consensus as to when labour begins, some hospitals accept women at the very beginning of labour, which tends to promote more interventions, while others refuse women until they are close to delivering, which gives them little time to find a bed.[7]

A second problem is that the epidemic of caesareans contributes to the shortage of beds. An uncomplicated vaginal delivery means a hospital stay of 24 hours, against 72 hours for an uncomplicated caesarean. Furthermore, availability of beds depends on the number of beds needed for post-delivery and neonatal care, especially for high-risk pregnancies. In São Paulo, due to the caesarean epidemic, a significant number of neonatal intensive care beds are needed for babies with iatrogenic prematurity, a common complication of elective caesarean.* When those neonatal beds are full, hospitals will not admit more women but will refer them on.

*A study of trends in low birthweight (LBW) in São Paulo compared birth cohorts in 1979 and 1994 and found an increase in the rate of LBW in higher income women, probably associated with elective caesarean section.[15]

The conveyor-belt approach: risking women's safety and bodily integrity

A third problem is that the shortage of beds is used to justify interventions not based on evidence. Thus, many doctors think that labour should be induced to free up beds, especially in public hospitals.

''Leaving women for too long in a bed during labour is a waste of space and limits the number of cases we can attend to. That is the reason why they have to induce all deliveries.'' (Medical resident, São Paulo)[7]

''I compare this to a construction site: you cannot stop. You cannot go by the book, nor wait for nature to act. I put everybody on pitocin.'' (Obstetrician-gynaecologist, Rio de Janeiro)[6]

Apart from the medical risks, induction and acceleration of labour are considered very painful by women. Some providers believe that increasing the pain is accepted by women since it makes labour shorter.[6,7,16] In Rio Grande do Sul, older women argued that induction and increased pain from pitocin often helped in obtaining a caesarean section, as ''proof'' that labour would not succeed.[17] These interventions, the so-called ''conveyor-belt obstetrics'',[18] are part of routine care in Brazil.

Many interventions to expedite labour and birth have unintended effects. Often these new problems are resolved with further interventions. This chain of events has been called the ''cascade of intervention'' and includes using various medications to induce labour, artificially rupturing the membranes before or during labour, using back-lying positions for labour or birth, episiotomy and so on.[19] Other obsolete interventions, although proscribed by medical textbooks as very risky, such as the Kristeller manoeuvre (fundal pressure, i.e. a doctor or nurse push on the abdomen to speed delivery), are still frequently used.[6,7,16] Providers recognise that women reject it:

''About Kristeller, personally I don't like it… women also don't like it, and sometimes the situation in the delivery room becomes very aggressive.''[16]

Clearing the ward is also used by providers to control their workload and have enough time to

sleep before their next shift. Leaving the ward full for the next shift is considered bad practice, so doctors consider it their duty to "clean" the ward using induction or caesarean section.[6,7,16]

"If you feel that the patient is taking too much time, you have to have resolution… I would be ashamed to hand over a full shift like that." [6]

In São Paulo, some university hospitals use routine forceps deliveries for all primiparae, with the aim of speeding up labour or for training purposes, regardless of clinical indication (Dr Jorge Kuhn, Professor of Obstetrics, Universidade Federal de São Paulo, personal communication, December 2003). A recent study reports that delivery with forceps is associated with a ten-fold increased risk of perineal injury compared to non-instrumental deliveries.[20] Perineal injuries are associated with anal and urinary incontinence, poor sexual function, post-partum pain and more difficult breastfeeding and bonding.[21]

Training of new providers in episiotomy and forceps delivery can be done using prosthetic models rather than women's bodies. Activists argue that learning clinical judgement, correct indications and respect for women's right to bodily integrity are the skills providers need to learn in the delivery room.

"Residents enter a hospital and start to hunt for pathologies. When a woman in labour shows up with no complications they do not know what to do. Surgical knowledge is easier… The more passive the patient, the easier for medical practice." (Medical professor, São Paulo)[7]

In 2003, Globo TV Network, a major Brazilian channel, in a programme about pregnancy (*Grávidas*), presented the "natural childbirth" of one private patient as follows: the woman was in a horizontal position, under epidural anaesthesia. She had an episiotomy and a Kristeller manoeuvre. Seeing this, it is not surprising that many women dread vaginal birth. In the words of this middle-class pregnant woman on an electronic forum:

"My friend visited her cousin and baby, and told me crying that her chest and abdomen were full of bruises, she'd had an episiotomy bigger than the Rio-Niterói Bridge, and the baby had a deformed head because of the forceps. She said I was irresponsible even to think about a vaginal birth." [22]

It is time to recognise the painful, harmful and unscientific practices in maternity care as a public health and human rights problem.

Caesarean section: "the cut above"

Caesarean section is performed in over two-thirds of births in the private health sector in Brazil where, theoretically, women have more choices. Several studies that have sought to understand whether and why Brazilian women prefer caesareans to vaginal birth show that most women declared a preference for a vaginal birth over a surgical one. However, through processes such as over-estimating fetal risk or interpreting maternal pain as a demand for caesarean, as well as their own schedules and convenience, doctors decide to do caesareans despite women's wishes, especially in the private sector. Another factor which seems to promote professional belief in the superiority of caesareans is concern to preserve the woman's genitals.[23–28]

A typical arrangement in the private sector in São Paulo is to schedule all women around 38 weeks of pregnancy for a collective caesarean day, the so-called "surgical day".[29] In the private sector, there is virtually no control over caesarean rates, which are as high as 80–90% of all births.[25] In São Paulo State, 59 private hospitals have caesarean rates over 80%. For women with more than 11 years of schooling in São Paulo (who are more likely to have a higher income level and use private services), the chances of having a caesarean are over 85%. The São Paulo Medical Council sampled 99 public and private hospitals and found a caesarean rate greater than 35 per 100 births for 82% of the hospitals, greater than 50 per 100 births in 63% and greater than 70 per 100 births in 36% (24% of the public hospitals and 40% of the private ones).[30]

A government initiative limiting reimbursement of childbirth costs to a 30% caesarean rate in the public sector since 1998 has had an impact on the official rates in SUS services. However, in a multicentre study by the Health Ministry in 2001 in five states, comparing

type of birth data in the national live-birth registration system (SINASC) with figures presented by the hospitals, the number of vaginal births in public hospitals was 49.3%. Initiatives to reduce the caesarean rate seemed to be better accepted by public health policymakers than by hospital directors and obstetricians. It also appeared that the figures were frequently massaged by registering some caesareans as vaginal deliveries in order to meet the official target.[31]

Episiotomy: ''the cut below''

''I know I shouldn't perform episiotomy as a routine, I know all the evidence. But when I see the baby's head on the vulva… my hand goes by itself.'' [7]

Episiotomy has been routinely used since the middle of the 20th century, in the belief that it facilitates birth and preserves women's genital integrity. Since the mid-1980s there has been enough scientific evidence to recommend abolishing episiotomy as a routine procedure, however. Its use is now advised in a maximum of 15–30% of cases or less,[34] where there is evidence of fetal or maternal distress, or to achieve adequate progress when the perineum is responsible for lack of progress.[2] Routine episiotomy is not justified: it has no benefit for mother or infant, increases the need for suturing of the perineum and the risk of complications at seven days post-partum, and produces unnecessary pain and discomfort. For example, a rigid perineum is frequently a consequence of a previous episiotomy.[21]

''Where do you think surgeons of any speciality do their first stitch? Here, it is always an episiotomy.'' (Doctor, São Paulo)[7]

''It is difficult to observe episiotomy training without feeling sorry for the woman. The woman is lying there having contractions, and they have to try numerous times with the needle until they find the right spot for the anaesthesia. Then after the birth, there is a very long wait before they do the suture, and some hardly know how to handle the surgical materials or tie the stitch.'' (Doctor, Rio de Janeiro)[6]

The extent of pain women experience in childbirth in Brazil is a marker of where they delivered. Women attended by private doctors who have painful procedures such as induction, episiotomy and Kristeller are given an epidural. For women using the SUS, however, episiotomy and repair of perineal tears are done with local anaesthesia. The amount of pain women experience during perineal suturing is very poorly studied, although anecdotal evidence suggests that the procedure can be associated with considerable pain.[33]

''… the patient had a perineal tear. During stitching, she cried from the first to the last stitch.'' [34]

In a study conducted in Latin America between 1995 and 1998, nine out of ten primiparous women who gave birth vaginally in a hospital had an episiotomy. In Brazil, the rate was 94.2%. This proportion was similar in public and private hospitals, primary care and referral hospitals, and whether attended by doctors or midwives. Thus, the unnecessary and routine use of episiotomy in Latin America has been wasting around US $134 million annually on the procedure alone, without counting the additional costs of resulting complications.[35]

There are no official data in the SUS system, but episiotomy is included in the birth assistance package, as part of standard care. As one of the most used obstetrics handbook in Brazil stresses:

''Passage of the fetus through the vulva and perineum is rarely possible without damaging the integrity of maternal tissues, with possible multiple lacerations and rupture, leading to irreversible looseness of the pelvic floor… Episiotomy is therefore almost always unavoidable in the primiparous woman, and in the multiparous one in whom it has been done before.'' [36]

Sexuality and childbirth care

In Brazil, one of the main arguments used in favour of both routine episiotomy and caesareans is that vaginal birth makes the vaginal muscles flaccid, compromising women's sexual attractiveness. However, according to scientific evidence, routine episiotomies damage vaginal structures rather than protect them. Women whose infants were delivered over an intact

perineum reported the best outcomes overall, whereas perineal trauma and the use of obstetric instrumentation were factors related to the frequency or severity of post-partum dyspareunia, indicating that it is important to minimise the extent of perineal damage during childbirth.[40]

Vaginal birth is being treated as if it carries a high risk to women's health and sexual life. Considering that there is no risk-free human experience, it is necessary to assess how much damage arises from the natural process of birth and how much is the result of unnecessary or harmful interventions. The large majority of women can have a safe and satisfying vaginal birth, with vaginal tonus better after delivery than before if they receive assistance based both on scientific evidence and on their sexual and reproductive rights. This synergy is not only possible but also necessary.

The post-partum period is an opportunity for women to do pelvic floor exercises to maintain vaginal tonus and receive advice on preventing urinary incontinence.[38,39] Yet this orientation is generally absent in antenatal and post-natal care and in gynaecological care in general in Brazil. The assessment, management and prevention of pelvic floor dysfunction, including its sexual dimensions, remain a neglected part of the education and training of many health care professionals. Inaccurate knowledge, myths and misconceptions of the incidence, cause and treatment of pelvic floor dysfunction abound.[40] Many women, even health care providers, do not know how to identify, contract and relax the pelvic muscles. If this information is not part of routine care, pregnant women have to press to receive it.[41]

In Brazil, notions of active–masculine and passive–feminine[42] reinforce the medical construction of the vagina as a passive organ, either tight or flabby (as experienced by the phallus during intercourse), in opposition to the understanding of the vagina and vulva as active, muscular and erectile tissue, able to relax and contract.

THOMAS HOEPKER / MAGNUM PHOTOS

Dancer at the Amazona Fish Festival, Brazil, 2001

Dissection of the vulva suggests that current anatomical descriptions of female human urethral and genital anatomy are inaccurate, underestimating the extension of the clitoral and vulvar structures.[43] Many of these structures can be damaged by interventions in delivery, not only the ability to contract and relax the muscles but also the blood vessels, nerves and erectile tissue.[44] Frequently the iatrogenic consequences and sexual sequelae of these interventions are confused with vaginal birth itself. Some women have been led to believe that natural birth is like rape, a horrible form of sexual victimisation, and that caesarean section is the way to prevent it.

''I would not have a normal birth, in no way. I would hate to have my legs open and my sexuality invaded and destroyed.''[45]

Doctors do not perform routine episiotomies because they are indifferent to women's suffering, or because they always ignore the evidence. Rather it is a matter of beliefs. If they believe the vulva and vagina are passive, it is difficult even for them to understand that these tissues are able to distend for birth and contract afterwards. Thus, through episiotomy, physicians deconstruct and reconstruct the vagina, in accordance with cultural beliefs.[46] The image that medical discourse suggests is that, after the passage of the baby, the partner's penis would be too small to stimulate or be stimulated by the now-stretched vagina.[7] Thus, delivery is perceived as rape, with the baby causing definitive damage to women's sexual function, and women needing to be returned to their ''virginal state''.[21]

Professionals we have interviewed often mention the *ponto do marido* (husband's stitch), intended to make the vaginal opening even tighter after delivery. Frequent complications are vulval and vaginal pain, scarring problems and deformities that need further surgical correction.[7] Long-term consequences for sexual relations of episiotomy need further study.

''… we have colleagues who cripple women. Some episiotomies we call 'lateral right hemi-bumectomy', because of the huge sutures, going into the patient's fanny, making it look like she has three bums. Not to mention those episiotomies that make the vulva and vagina crooked, which we call 'vulval stroke', you know, as happens when someone has a stroke and their mouth and face become asymmetrical?'' (Maternity director, São Paulo)[7]

Women accept routine episiotomy in Brazil, because most believe that it is medically necessary to protect themselves and their baby. Since episiotomy is the decision of the doctor, women assume the doctor is doing the right thing. If women believe they will have sexual problems and a flabby vagina after a vaginal birth and that episiotomy is a solution, they will agree to it. In a study in Uruguay, when asked if they believed that episiotomy was necessary, 11% thought it was not, 13% had no opinion and 76% believed its use was justified.[32]

''If I were to give birth now everything would be different… the most important, no episiotomy. It wouldn't matter if I had some tearing, I would not feel so uncomfortable when I was sitting down later – or now that I am 50, for sexual intercourse. More than ever, when oestrogen is decreasing, it hurts very much during penetration. I have talked to many women doctors like me, and many other women who feel the same.''[47]

In electronic forums where Brazilian women speak in favour of alternatives in childbirth, many have said they had sought a caesarean to avoid episiotomy, especially after a previous traumatic procedure in which they sustained long-lasting damage.[48]

Humanising childbirth in Brazil

In the Brazilian case, unnecessary caesarean section and episiotomy are also a problem related to social class and race. White and middle class women attending private sector services are more likely to get ''the cut above'' (caesarean), while black and poor woman using SUS (70% of Brazilian women) are more likely to get ''the cut below'' (episiotomy). As black women have different characteristics in relation to wound healing, with a tendency to have more problems with scarring and keloid formation,[49] they may be more exposed to complications from episiotomy repair scars. Not rarely, it is necessary to seek the services of a plastic

surgeon to correct the deviation and retractions of the vaginal labia after episiotomy.[50]

The expression ''humanisation of childbirth'' in Brazil means respect for and promotion of women's and children's right to evidence-based care, including safety, effectiveness and satisfaction. When women have access to good information, they understand that episiotomy is not always necessary. To get the care they want, some Brazilian women are now changing doctors during pregnancy, with the help of a very promising resource for change – electronic support groups and sites, for and by consumers who want evidence-based, humanised care. Women who chose caesarean because they did not know that an episiotomy-free birth was possible have set up a website to educate the public.[48]

Since 1993, there has been a National Network for the Humanisation of Childbirth (Rehuna) that includes progressive providers, policymakers, feminists, alternative healers, midwives and organised health service users' groups. The latter have several electronic lists, forums, sites and blogs, including the very active *Amigas do Parto* (Friends of Childbirth).[51] Brazilian feminists have been part of Rehuna since its foundation, defending the vision of a ''voluntary, pleasurable, safe and socially supported motherhood''.[29]

Since the mid-1990s several governmental initiatives, many of them in partnership with NGOs, have supported proposals to change childbirth assistance in Brazil, especially focusing on the reduction of caesarean rates. These include the establishment by the Ministry of Health of the *Dr Galba de Araújo* Award in 1998 for the most humanised maternity hospitals, a programme for training obstetric nurses and the Prenatal and Birth Humanisation Programme (PHPN) in 2000. In 2001, the Ministry of Health distributed a Portuguese version of the WHO manual for vaginal birth assistance to doctors and nurses all over the country.[52] At regional level, in various states, services with a humanised approach were created, both in the private and public sectors. There is a very promising programme for establishing Normal Birth Centres, with very successful experiences in several parts of the country, but in others it has met with strong resistance from more conservative sectors.[53]

Rehuna is campaigning for the right of SUS and private patients to companionship and social support during labour, a simple, cheap, effective and satisfying way to make birth a better experience for women.[2–5,54,55] In June 2003, Rehuna launched a Campaign against Routine Episiotomy. The first event was in São Paulo, with representatives from the College of Public Health, Federation of Brazilian Societies of Gynaecology and Obstetrics (FEBRASGO), National Association of Obstetric Nurses (ABENFO), policymakers, feminist NGOs, organised consumers, Medical Council, Brazilian Cochrane Centre and National Network on Health and Reproductive Rights, among others.

Inspired by the movement against female genital mutilation in non-western societies, routine episiotomy has been considered by many as a form of genital mutilation,[56,57] and gender violence committed by institutions and professionals.[58] Some are proposing changes in the terminology, calling unnecessary episiotomies ''iatrogenic genital lesion'', ''iatrogenic sexual damage'' or ''iatrogenic sexual wound''.[51] The high numbers of episiotomies has been considered as an archetypal case of violation of human rights in relation to health.[59]

The Campaign was an opportunity to combine the evidence-based and women's reproductive rights perspectives, through a partnership with the Latin American Centre for Perinatology (CLAP) and the Latin American Centre for Women's Rights (CLADEM). We are at present looking for the support of health authorities to follow the recommendations we have put forward, including for the training of providers, the introduction of informed consent for episiotomy in SUS services, and monitoring of progress.[51]

The prevention of unnecessary caesareans and episiotomies and the promotion of normal vaginal delivery with an intact perineum demand profound transformations in obstetric care. A change in gender stereotypes and better understanding of women's bodies is required before a change in the procedures themselves can be expected. That includes women's right to evidence-based information, privacy, freedom to choose position in labour and birth, the right to have a companion at birth and social support during labour, adequate pain control and prevention of iatrogenic pain, and promotion of pelvic exercises for a ''powerful''

vagina. Although the focus of Rehuna's campaign is the abolition of routine episiotomies, the broader aim is to contribute to changes in reproductive and sexual health care provision, promoting women's genital integrity, satisfaction and safety both in reproductive and sexual life.

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Résumé

Ces 50 dernières années, l'accroissement rapide de l'utilisation de la technologie pour déclencher, accélérer, réguler et surveiller l'accouchement a souvent abouti à des interventions erronées, inutiles et parfois dangereuses. Bien que la recherche ait montré que le moins d'interférence compatible avec la sécurité était le principe à suivre, au Brésil, l'accouchement par voie vaginale est encore traité comme s'il comportait un risque élevé pour la santé et la vie sexuelle des femmes. Cet article décrit l'impact du modèle d'intervention sur l'expérience qu'ont les femmes de l'accouchement et montre comment l'organisation des services publics et privés de maternité influence la qualité des soins obstétriques au Brésil. Le Brésil est connu pour ses taux élevés de césariennes pratiquées sur plus des deux tiers des naissances dans le secteur privé, où 30% des femmes accouchent. Le taux de 94,2% d'épisiotomie chez les femmes qui accouchent par voie vaginale, touchant 70% des femmes pauvres qui utilisent principalement le secteur public, reçoit moins d'attention. Un changement dans la manière dont le corps des femmes est compris devra précéder tout changement des procédures elles-mêmes. Depuis 1993, inspiré par des campagnes contre la mutilation sexuelle féminine, un mouvement national de prestataires de services, de féministes et de groupes de consommateurs préconise des soins fondés sur les recherches disponibles et l'humanisation de l'accouchement au Brésil, pour réduire les procédures chirurgicales inutiles.

Resumen

En los últimos 50 años, un aumento rápido en el uso de la tecnología para iniciar, aumentar, acelerar, regular y vigilar el proceso de parto llevó a menudo a la adopción de intervenciones inadecuadas, innecesarias y a veces peligrosas. Si bien se ha mostrado que la menor interferencia que sea compatible con la seguridad es el paradigma a seguir, en Brasil todavía se trata el parto vaginal como si presentara un alto riesgo para la salud y vida sexual de las mujeres. Este artículo describe el impacto del modelo intervencionista sobre la experiencia de parto de las mujeres, y muestra como la organización de servicios de maternidad públicos y privados en Brasil impacta la calidad de la atención obstétrica. Brasil es conocido por sus altas tasas de cesáreas innecesarias, practicadas en dos tercios de los partos en el sector privado, donde dan a luz 30% de las mujeres. Llama menos la atención la tasa de 94.2% de episiotomías en mujeres que tienen un parto vaginal, afectando a un 70% de las mujeres pobres que usan más el sector público. Se requiere un cambio en la comprensión del cuerpo de la mujer antes de que se pueda esperar un cambio en las intervenciones. Desde 1993, inspirado por las campañas en contra de la mutilación genital femenina, un movimiento de proveedores, feministas y grupos de consumidores promueve la atención basada en hechos y la humanización del parto en Brasil, con el fin de reducir las intervenciones quirúrgicas innecesarias.