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Public Policies for Promotion of Maternal-Infant Health in Brazil: Some Experiences with Adolescent Mothers in São Paulo

Aline Mizutani Gomes and Renato Alves

Abstract

This chapter introduces and discusses to what extent policies focused on promoting maternal and infant health through public health services are or are not effective in the coverage area. The discussion is based on accounts of adolescents—mothers or still pregnant—and the assistance provided to them and their children through these services. The accounts, which are derived from an independent program of home visits to accompany these adolescents, are complemented by observations made by the visitation team about whether assistance provided by health services promote maternal and infant health and the rights of children and adolescents. To provide context, we present a panorama of current public-health policies and services aimed at mothers and infants in Brazil, as well as some health indicators for this population. Finally, we discuss the possibilities and challenges of promoting the healthy development of mothers and their children in these contexts.

Keywords: public policies, promotion of maternal-infant health, adolescent pregnancy, prenatal, maternal-infant mortality

1. Introduction

Brazil is a country of continental dimensions, with enormous geographic and cultural diversity and with major problems of social inequality. To get an idea of the regional differences, while the north region is covered by the Amazon rainforest, has the largest population that self-identifies as indigenous, and accounts for 42.25% of Brazil's territory with the lowest population density, the southeast region is the most populous, has the largest urban center, greatest industrial output, and accounts for more than 50% of everything the country produces (in GDP terms) [1].

Furthermore, in the past decade, the country has undergone both advances and setbacks, in terms of politics and economics, that have directly influenced the development of its public policies, including those in regard to maternal-infant health, the focus of this chapter. In this sense, although currently there are important investments in programs focused on reducing maternal-infant mortality rates, humanizing services, and promoting the healthy development of the population, the country still has a long way to go.

In historic terms, the passage of the 1988 Constitution was an important step in the process of changing the paradigm of Brazilian health policies, in that it began to address the concept of health as a right of all citizens and the obligation of the state. This prioritization led to the creation of the Unified Health System (Sistema Único de Saúde or SUS), which is geared toward providing free services to all individuals, ranging from the simplest outpatient consultations to more complex surgeries, and which represents one of the largest public health systems in the world, offering integrated, universal, and egalitarian access to all Brazilian citizens [2, 3].

SUS promotes the regionalization of services; hierarchization into increasingly complex levels, depending on the needs of the population being served; the decentralization of command, giving autonomy to each sphere of power to make its decisions; and the participation of the population in the system's day-to-day operations. All these principles seek not only to prevent illnesses but also work toward promoting health, quality of life, economic and social development, and the reduction of inequalities [4].

Also worth mentioning is the Child and Adolescent Statute (Estatuto da Criança e do Adolescente or ECA) of 1990, which includes eight articles dedicated to rights to life and health. This statute has been praised for the advances it provides in the form that children and adolescents are viewed in the country. As a result, it seeks to ensure dignified conditions of life, starting even before birth, considering that articles 7 and 8 guarantee that pregnant mothers and newborns have access to pre- and perinatal services by way of public policies that promote healthy development [5].

Also included in the social advances relevant to the promotion of health and improved quality of life of the population—especially mothers and children—we should note the role of the Bolsa Familia Program. Created in 2003, this is a wealth-transfer program at the federal level that helps families living in poverty and extreme poverty to break the intergenerational cycle of poverty. Furthermore, it seeks to contribute to the expansion of access to public services that represent basic rights in the areas of health, education, and social assistance, representing one of the main factors that have led to the reduction in infant mortality [6].

2. Brief overview of maternal-infant health policies

As noted above, the Brazilian health system is organized around the SUS, for which financing is carried out through resources raised from taxes and social contributions, and which is managed at the national level by the Health Ministry. The ministry is also responsible for creating and monitoring policies and activities that are implemented according to the needs of municipal managers, in accordance with the principle of decentralization [2, 8].

Among the main structural policies of the SUS, we highlight the Family Health Strategy (ESF), a program used to structure basic services—that is, the first level of health services and the population's entryway for receiving services through the system. The main characteristic of the ESF is the establishment of a team of various professionals—composed of general practitioners or specialists in family health, a nurse practitioner or specialist in family health, nursing assistant or technician, and community health agents (ACSS)—and the establishment of a territory for them to cover, thereby complying with the principle of regionalization of the SUS. As a result, the unique aspect of this program is that it allows the health team to become acquainted with the local reality and the needs of the population, establishing links between the team and users, which in turn increases the adoption of treatments and interventions proposed by the health professionals [7, 8].

The ESF health team is linked to the local Basic Health Unit (UBS). At the UBS, Brazilians can receive free basic treatment in pediatrics, gynecology, general medicine, nursing, and odontology. The main services offered are medical consultations, inhalations, injections, dressing of wounds, vaccines, collection for laboratory exams, odontological treatment, referrals to specialists, and the provision of basic medications. Generally, the UBS is located close to the user's home, and it is there that services are carried out for prenatal, post-natal, and infant care [7, 8].

Under the *National Policy of Basic Services* [7], it was determined that each UBS should serve at most 12,000 inhabitants in large urban centers, with a maximum of 750 people per ACS, and 12 ACSs per Family Health team. Each Family Health team should be responsible for at most 4000 people, with the recommendation being an average of 3000 people. These limits are important in order to ensure quality service, especially under the logic of the ESF, which prioritizes ties with the population.

Among the specific policies of maternal-infant health, the first we will highlight is the *National Policy for Integrated Women's Health Services* [9], which:

"incorporates, with a gender focus, a holistic approach and the promotion of health as its guiding principles, and seeks to consolidate advances in the field of sexual and reproductive rights, with an emphasis on improved obstetric services, family planning, attention to unsafe abortions, and combating domestic and sexual violence."

This policy was an update of the 1983 *Program of Integrated Women's Health Services* (PAISM), which was an important step in Brazilian women's mobilization to defend their reproductive rights. Therefore, the National Policy for Integrated Women's Health Services represents an advance in terms of integrating women's health services, with special attention to family planning, educational activities to prevent undesired pregnancies and sexually transmitted diseases, and in terms of encouraging corporal autonomy [9].

Even with these advances in the attention given to women's health services, the impact on indicators was lower than expected. That is why, in 2000, the *Program for the Humanization of Birth and Pre-Natal Services* (PHPN) was implemented, with the main objective being the reduction in high rates of maternal, perinatal and neonatal, mortality through the provision of improved access, coverage, and quality of prenatal, birthing, and infant assistance. One of the initiatives of this program is the right of pregnant mothers to visit and create ties with the maternity ward where they will be served, and the guarantee that mothers can have a companion present during labor, delivery, and postpartum periods [10].

The issue of humanizing services has been shown to be directly related to the quality of services provided, and the capacity to make resolute and satisfactory decisions. This is not just a labeling matter, but one of creating a hospitable environment where rights are recognized, specific needs are respected, and knowledge is shared. One of the major impediments to carrying out any public policy is precisely in the passage from theory to practice. It is not enough to have a progressive discourse and innovative ideas if these are not based on concrete experiences, synchronizing the needs of the population with the proposed intervention [11].

In this sense, humanized prenatal and infant services imply a reorganization of the work processes, facilitating access to health services, and integrating new levels of attention. Furthermore, the policy provides new resources to pay for these services in order to assist most municipalities in implementing these activities according to the following criteria: carrying out the first prenatal consultation before the fourth month of pregnancy; guaranteeing at least six prenatal consultations, preferably with one coming in the first trimester, two in the second trimester, and three in the third trimester of pregnancy; one consultation up to 42 days after

birth; lab exams such as (a) ABO-Rh during the first visit, (b) one Venereal Disease Research Laboratory during the first visit and another close to the thirtieth week of pregnancy, (c) routine urine tests, with one during the first visit and another close to the thirtieth week of pregnancy, (d) monitoring blood sugar levels, with one test during the first visit and another close to the thirtieth week of pregnancy, (e) hemoglobin/hematocrit exam during the first week, and offering to test for HIV, with one exam during the first visit in municipalities whose population is greater than 50,000; and applying tetanus vaccines up to the immunizing (second) dose or a reinforcement dose for women who have already been immunized [10].

In 2011, the Health Ministry created the *Stork Network*, a new program that sought to provide even more thorough women's health services at all stages of life, including actions geared toward assisting children up to 2 years of age. The structural concepts included range from respect for cultural, ethnic, and racial diversity; promotion of equity; focus on gender; expanding access to and improvement of prenatal care without unnecessary interventions; guaranteeing safe deliveries; and healthy development within the scope of the SUS. It also includes professional training as a strategy to achieve these improvements—after all, in addition to physical and technological facilities, services that seek to promote health in a holistic way depend on competent and sensitive professionals capable of taking a wider view than those circumscribed by biomedical aspects [12].

3. Pregnancy during adolescence

Between 2003 and 2016, on average, 6.6% of adolescents between 15 and 19 years of age became mothers. It is possible to note that during this period of time, the rate declined from 7.4% (2003) to 5.7% (2016). Despite this reduction, Brazilian rates are still very high when compared with the US and Canada. In 2015, rates for these countries stood at, respectively, 2.2% [13] and 1.1% [14].

The average rate of adolescent pregnancy in the city of São Paulo—the country's largest city—is a bit lower than the national average, coming in at 5.2% for the 2003–2016 period. However, somewhat differently than what happened nationally, the rate of pregnancy among adolescents remained relatively stable during this period, and showed signs of decline only starting in 2015 (**Figure 1**).

Pregnancy and motherhood during adolescence are topics that have been discussed a lot, the subject of analyses by different areas, and in general treated as a problem that creates difficulties not only for the adolescent mothers but also for their children and, at the end of the day, to society as a whole.

However, for a long time, the age range of 15–19 years was considered the ideal period for women to begin their reproductive lives. Among indigenous population, for example, teen pregnancy is viewed as natural. Furthermore, regional differences in terms of adolescent pregnancy is obvious, with pregnancy rates among 15–19-year olds in the north region of Brazil reaching 23.2%, while in the south, this rate is 13.8% (2016). Therefore, we can conclude that the notion of adolescent pregnancy being a problem reflects more the social, cultural, economic, and demographic issues of a community than biomedical risks. And as such, we cannot homogenize or generalize about the conceptions of what leads an adolescent woman to become pregnant [15–18].

According to Heilborn et al. [18], pregnancy during adolescence could be:

“[...] unexpected or the result of planning; could result in bonds, with subsequent separation; in more stable and lasting relationships; [...] it could result in irresponsible parenting or, to the contrary, turn out to be an antidote to anomie for adolescents [...] non-cohabitation, partial cohabitation, or dual residences.”

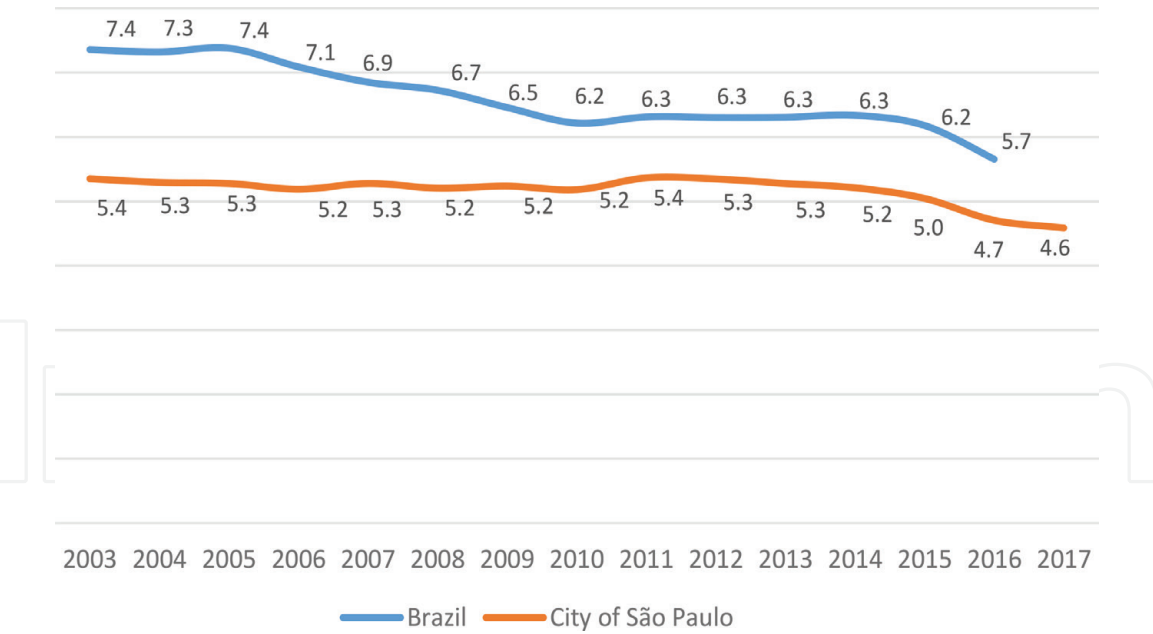


Figure 1.
Proportion of pregnant adolescents between 15 and 19 years of age in Brazil and in the city of São Paulo.
Source: DATASUS/TabNet/Municipal Health Department of the City of São Paulo [22].

Another major point of debate is whether pregnancy during adolescence leads to an increase in school drop-out rates. However, Barbosa [19] showed that the rate of fertility among youths who are not in school is much higher than that for youths who are still in school. Based on this data, it seems that in reality, being out of school leads these youths to have no outlook other than the alternative of having children, and not the other way around.

Furthermore, there are significant differences in the educational trajectories of different social classes. While the experience of maternity among adolescents with higher incomes tends to only temporarily interrupt their school career—which for the most part is linear and generally resumed sometime after the birth of the child—among poorer classes, adolescent pregnancy proves to be much more harmful to the continuity of this trajectory, especially when there is an imperative need for the adolescent to reconcile mothering activities with some type of work that ensures the livelihood of the mother and her child [18].

Similar to what happens across the different regions of Brazil, in the city of São Paulo there is an inverse relationship between economic, social, and cultural conditions and adolescent pregnancy. To get an idea of the scale of this disparity, the average rate of adolescent pregnancy among the three wealthiest regions of the city is approximately 0.5%, whereas among the three poorest regions that rate is 7.5% (**Figure 2**). In other words, the chances of an adolescent from a poorer neighborhood getting pregnant are 16 times greater than for an adolescent in wealthier districts.

With regard to the biological risks of adolescent pregnancy, we should distinguish between pregnancy that occurs between the ages of 10 and 14 (which represents just 0.8% of cases) and pregnancies that occur between the ages of 15 and 19. Instances of restricted intrauterine growth, feto-pelvic disproportion, and retarded uterine development occur more frequently among girls between the ages of 10 and 14 years. We also note that situations of maternal or infant death, premature birth, low birth weight, gestational diabetes, anemia, and pre-eclampsia are much more closely related to precarious prenatal and birthing assistance than to the age at which pregnancy occurs [20, 21].

According to data from the Municipal Health Department, the number of weeks of pregnancy is not significantly different across various age groups. The majority

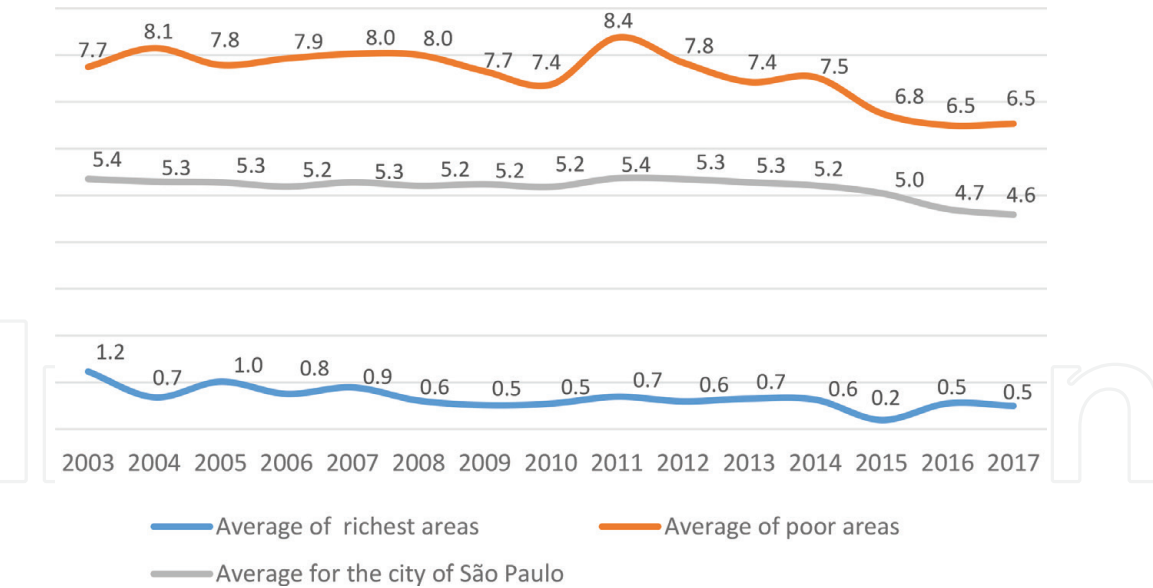


Figure 2. Comparison between average rates of adolescent pregnancy. Source: DATASUS/TabNet/Municipal Health Department of the City of São Paulo [22].

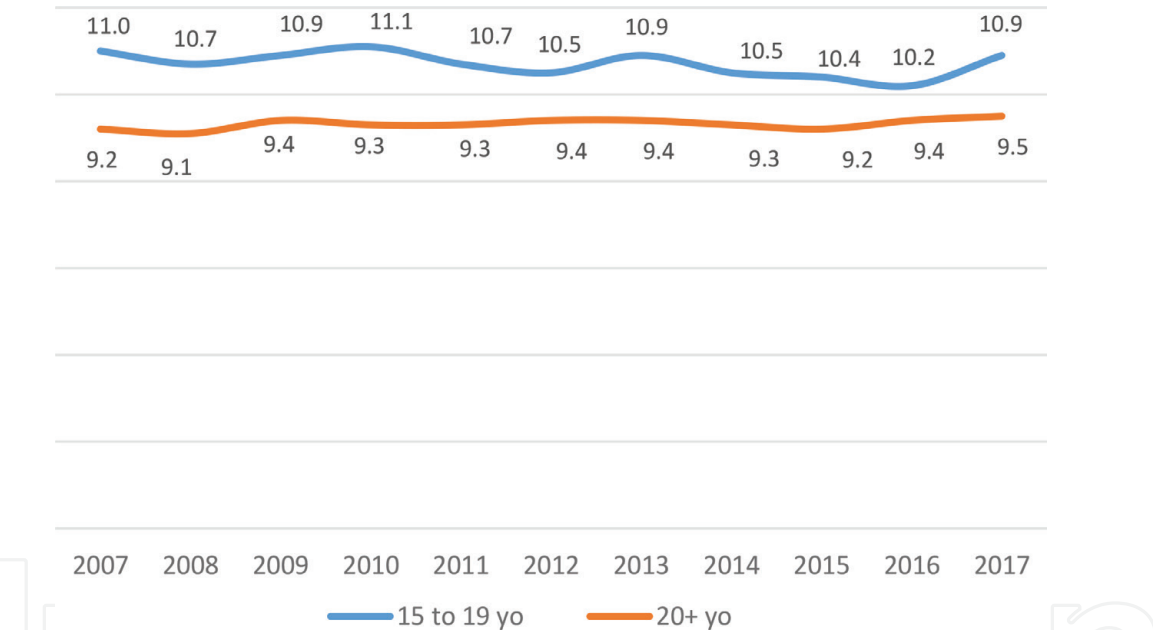


Figure 3. Low birth weight (<2,500 kg) for mothers between 15 and 19 years, and mothers older than 20 years, in the city of São Paulo between 2007 and 2017. Source: DATASUS/TabNet/Municipal Health Department of the City of São Paulo/Accessed July 15, 2018. Organized by: Centre for the Study of Violence of University of São Paulo.

of pregnancies in the city of São Paulo between 2007 and 2017 lasted between 37 and 41 weeks—that is, they went to term for both the population of 15–19-year olds (87.7%) and for the population older than 20 (89.0%). Comparing these two groups also showed no major difference in relation to premature births (where gestation lasts less than 36 weeks). General data for the city show that, during the 2007–2017 period, babies born at less than 36 weeks accounted on average for 10.9% of births to mothers between 15 and 19 years, and 10% for mothers older than 20 [22].

With regard to the number of children with low birth weight, there is a slight variation between adolescent mothers and mothers older than 20. During the 2007–2017 period, in the city of São Paulo, the proportion of children with low birth weight (less than 2,500 kg) was 10.7% among 15–19-year-old mothers, and 9.3% for children born to mothers older than 20 (Figure 3).

Therefore, denaturalizing the view that adolescent pregnancy is a problem is essential to changing the discourse and, above all, rethinking practices related to pregnancy and motherhood during this period of life. This is not to say that the phenomenon should be treated as something normal, because it is not—but neither is it something abnormal. The proposition here is that we should discuss this matter outside of the scope of a universalizing and naturalizing view of normal/abnormal in order to seek out a new way of thinking that will allow for more humanized practices [15].

4. The Health Infancy project

The data that will be discussed below are from the Health Infancy project, an initiative by the Nucleus for the Study of Violence at the University of São Paulo (NEV-USP) that seeks to promote the healthy development of children born to teen mothers (13–19 years) starting at gestation all the way to 2 years of age. Through weekly home visits, participants received guidance about various issues related to gestation and infant development and were able to discuss with the visitors any questions or problems they had related to maternity. The strength of the project lies precisely in the relationship that is established between the adolescent and the visitor—who is also a mother from the same community—trained not only to transmit information but primarily to pay attention to the demands of the participant and her child in order to hear them out and address their anxieties and fears during this phase [23].

We opted to organize the discussion into topics and, based on both statistical data and concrete examples shared by the adolescents, reflect on how the proposals included in the health policies are carried out in day-to-day activities. We know that public policies will never fully account for the diversity of real-life situations; nevertheless, it is necessary to permanently improve policies in order to ensure their effectiveness as much as possible.

The Health Infancy project has been carried out since 2009 in the Jardim Ângela neighborhood in the southeast region of the city of São Paulo. In the 1990s, this region was considered by the United Nations to be the most violent urban region in the world, and currently still ranks among the city's most vulnerable neighborhoods. Nevertheless, the region has access to a free public health system and, at least in terms of prenatal, delivery, and infant care, the population is served by 18 UBSs, 2 emergency rooms, and 1 hospital.

In comparison with other regions of the city of São Paulo, Jardim Ângela is the sixth largest in terms of the number of pregnant adolescents. Rates are not only higher than the average for the city, but also present the greatest variation. Between 2003 and 2017, the rate of pregnant adolescents between 15 and 19 years of age in Jardim Ângela averaged 6.8%. In the graph below, we can see that during this period the rate was stable between 2003 and 2008, rose between 2009 and 2014, and fell starting in 2015 (**Figure 4**).

4.1 Finding out about pregnancy and utilizing health services

When a woman finds out she is pregnant, this represents a formative moment in any woman's life. When this woman is an adolescent, right away the perception is that the pregnancy was unplanned and as a result it will be badly received, especially by the girl's family. However, despite the initial shock upon receiving the news, and concern about how life will be from that moment onward, it was common for adolescents to say that they desired to be mothers, and for them to demonstrate happiness and satisfaction with the pregnancy. Furthermore, even in those

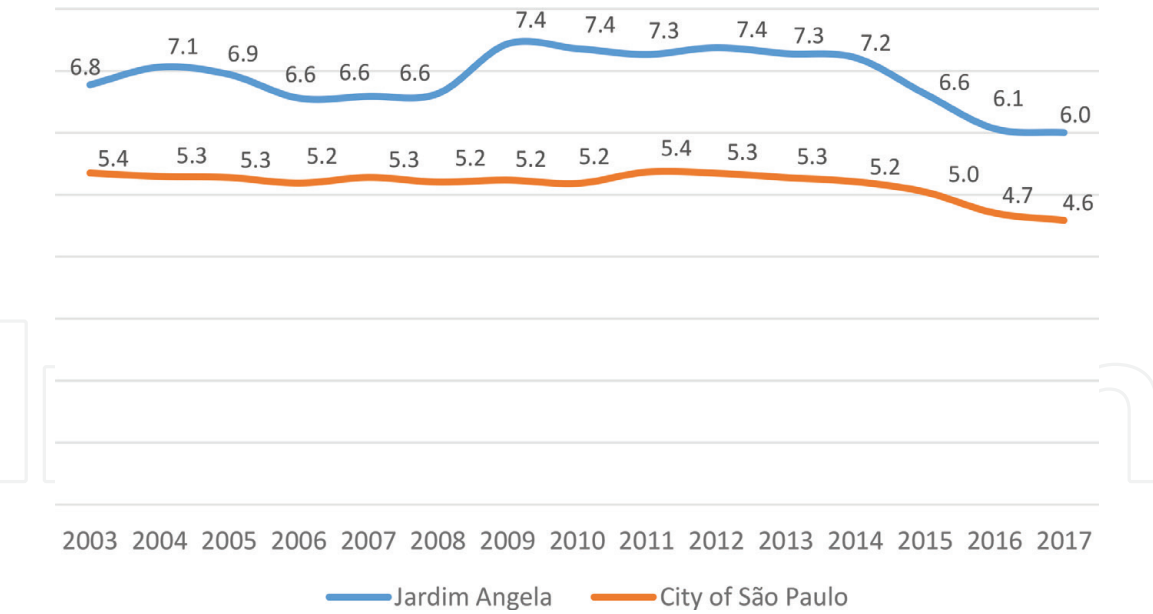


Figure 4. Comparison between average rates of pregnant adolescents in Jardim Ângela and in São Paulo. Source: DATASUS/TabNet/Municipal Health Department of the City of São Paulo/Accessed July 16, 2018. Organized by: Centre for the Study of Violence of University of São Paulo.

cases where the family expressed dismay with the news of the pregnancy, primarily because they knew the difficulties that would be faced—lack of economic resources, dropping out of school and the subsequent problems in entering the labor market, and the adolescent’s lack of maturity to care for a baby, among others—soon there was acceptance and increasing family support. It is also worth noting that in many cases, the adolescent had already left her parents’ home and lived with her partner and the child’s father, such was the couple’s desire to have children [15, 24].

Still, the common perception that adolescent pregnancy is always unwanted and unplanned is oftentimes also held by health professionals. The discourse is usually focused on the negative repercussions of the pregnancy, both for the mother and for the child, and also for society as a whole. Knowledge and practices linked to adolescent pregnancy tend to be activated from the perception of risk. Therefore, upon reaching the UBS to confirm that they are pregnant, many adolescents say that they suffer negative or prejudiced comments. This reaction by health professionals runs counter to the stance proposed by humanized services, in that they do not welcome reproductive demands or recognize the adolescent as a holder of rights capable of making autonomous decisions [15].

Starting in 2012, the city of São Paulo’s Department of Health began to publish data about the month of pregnancy during which prenatal consultations began. The large majority of pregnant women began to have consultations during the first 3 months of pregnancy. However, some differences were noted between women aged 15–19 and women older than 20. During the 2012–2017 period, we noted that pregnant women older than 20 began to visit the doctor earlier than pregnant women between 15 and 19. Among pregnant women older than 20, 84.1% began prenatal care during the first 3 months: 30.3% starting in the first month, 36.8% during the second month, and 17% during the third month. Among pregnant women aged 15–19, 73.6% began prenatal care during the first 3 months: 17.8% during the first month of pregnancy, 34.2% during the second month, and 21.6% during the third month [22].

Similar to what happened in the city as a whole, the Jardim Ângela neighborhood saw the large majority of pregnant women begin their prenatal consultations during the first trimester. Among pregnant women older than 20, 86.4% had prenatal

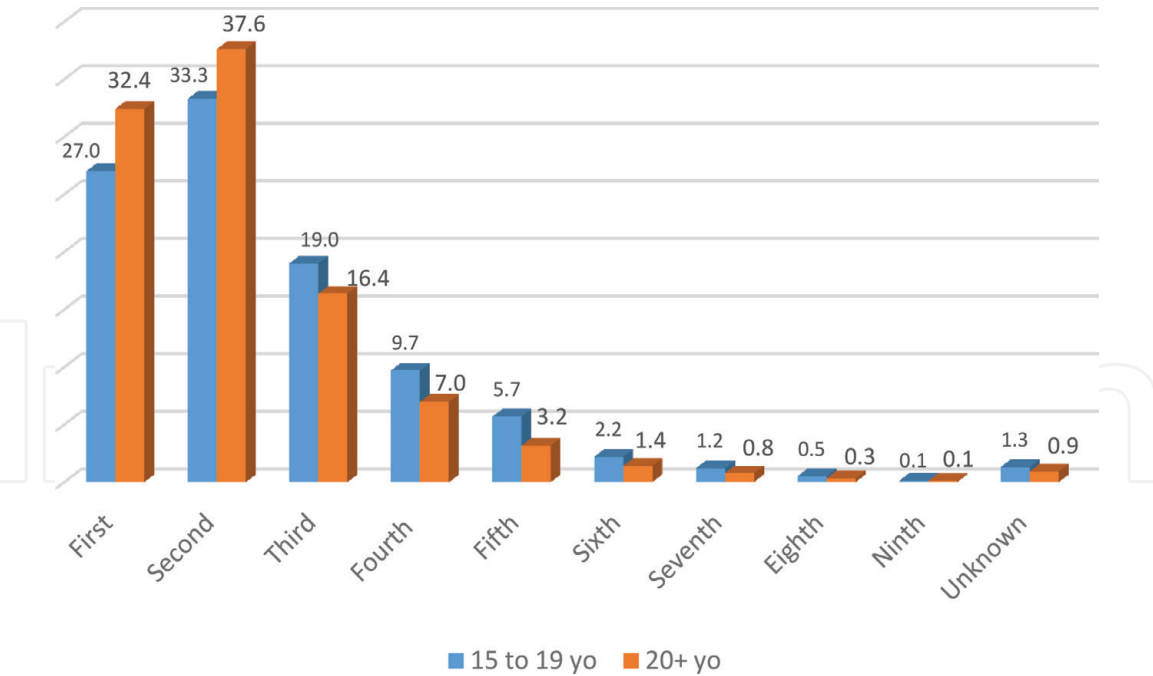


Figure 5. Percentage of pregnant women who carried out prenatal consultation in Jardim Ângela, by month. Source: DATASUS/TabNet/Municipal Health Department of the City of São Paulo/Accessed Jul 16, 2018. Organized by: Centre for the Study of Violence of University of São Paulo.

consultations during the first trimester: 32.4% during the first month, 37.6% during the second month, and 16.4% during the third. Among pregnant women aged 15–19, 79.3% began prenatal consultations during the first trimester: 27% during the first month, 33.3% during the second, and 19% during the third month (**Figure 5**).

Comparing these data to citywide data, we note that the figures for both groups are higher than the city average. We also note that, similar to what happens in the city as a whole, in Jardim Ângela, pregnant women older than 20 tend to start their prenatal visits earlier than pregnant women aged 15–19. On the other hand, in Jardim Ângela, there is a larger proportion of pregnant women aged 15–19 who start receiving prenatal care during the first month of pregnancy.

4.2 Prenatal

We know that proper accompaniment during the prenatal period and delivery is fundamental for ensuring adequate conditions of survival for mothers and their babies [25]. The São Paulo Municipal Secretariat of Health, in accordance with federal policies, establishes that pregnant women should have monthly consultations (or at least 7), lab and ultrasound exams, free transportation vouchers to and from the exams and consultations, and visits before delivery. Furthermore, prenatal care should include spaces where mothers can voice their questions, worries, and difficulties; receive emotional support and encouragement to breastfeed, including time to exchange tips with other mothers; and also include the involvement of family members and community members in this process [12].

In the city of São Paulo, pregnant women who have seven or more prenatal visits not only represent the majority, but their numbers have been climbing over the years. However, when comparing data for the group of 15–19-year olds to those older than 20, we note some differences. In the 2007–2017 period, 77.6% of women older than 20 had seven or more prenatal visits, while 64% of those between 15 and 19 did so. For pregnant women older than 20, 17.1% had 4–6 prenatal consultations, compared with 26.5% for women aged 15–19 (**Figure 6**).

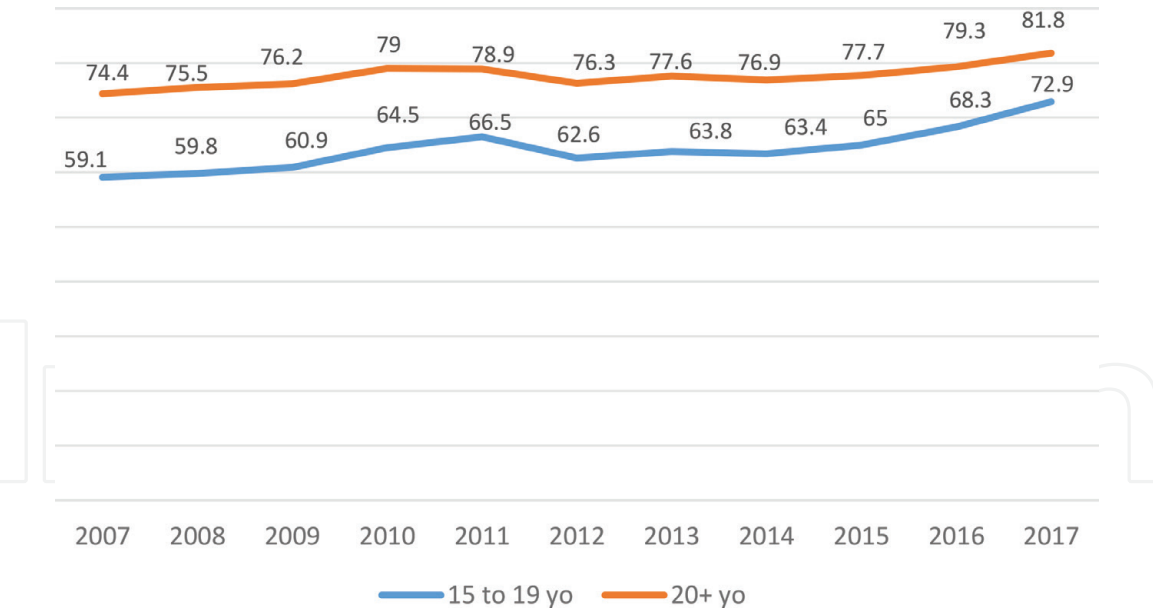


Figure 6. Percentage of pregnant women who had seven or more prenatal consultations, for 15–19-year olds and for women older than 20 in the city of São Paulo. Source: DATASUS/TabNet/Municipal Health Department of the City of São Paulo/Accessed Jul 16, 2018. Organized by: Centre for the Study of Violence of University of São Paulo.

When we look at data from Jardim Ângela and compare them with those for the city, we note that pregnant women who had seven or more prenatal visits also are the majority, and that Jardim Ângela women report higher rates than the average for the city over the same period. We also see the same difference between women aged 15–19 and women older than 20. Pregnant women older than 20 more frequently had seven or more consultations (81.4%) than those aged 15–19 (74.3%). Women who had 4–6 visits accounted for 14.8% of pregnant women older than 20, and 19.9% of those aged 15–19 (Figure 7).

Among the adolescents accompanied by the Health Infancy project, more than 90% had prenatal exams at the UBS closest to their home. In general, there were no reports of difficulty in accessing this kind of service, nor in carrying out the exams—except ultrasounds, which have a long wait time. In this sense, then, there seems to be a compatibility between what is proposed and what is in fact accessed by the population. What still needs to be debated is the quality of these services. The adolescents say that they were well received, especially by the nurses, but they also complained about this relationship oftentimes being merely prescriptive, that the health professionals’ recommendations were not fully understood, that the pregnant women were not welcomed, and in some cases they noted a prejudiced tone in the health professionals’ attitudes [15].

The fact that they are adolescents reinforces the hierarchy of those who know—the professional—and those who need knowledge—the adolescent—which creates difficulties for the building of a more horizontal relationship. Oftentimes, out of fear or embarrassment, the adolescents failed to ask questions or to follow the recommended guidelines, which could impact the baby’s development. In this sense, it is of utmost importance that the health professionals be aware of the peculiarities of this kind of assistance [26].

4.3 Childbirth

The moment of childbirth is the one most feared by adolescents. Although prenatal consultations provide a space for them to prepare themselves for delivery,

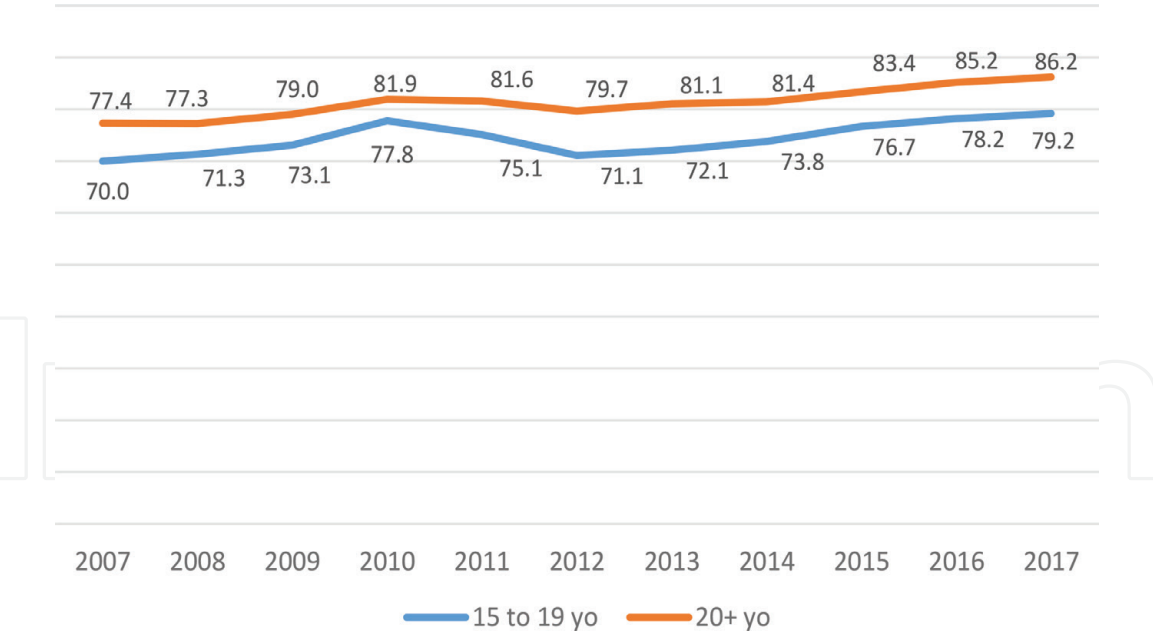


Figure 7.
Percentage of pregnant women who had seven or more prenatal consultations, for women aged 15–19, and for women older than 20 in Jardim Ângela. Source: DATASUS/TabNet/Municipal Health Department of the City of São Paulo/Accessed Jul 16, 2018. Organized by: Centre for the Study of Violence of University of São Paulo.

what we see in practice is that the matter is little discussed, as are the fears and anxieties that surround this moment. In general, adolescents know that two forms of childbirth are possible—vaginal and caesarian section—and about the benefits of vaginal delivery; but the fear of the pain, the initial signs of labor, the procedures carried out—these are not discussed very much [15, 26].

It was clear from the accounts given by adolescents to the visitors that certain comments and attitudes of some health professionals contributed even more to the suffering they underwent during delivery. Not rarely, the sensations that the adolescents felt upon being admitted to the hospital were dismissed by the hospital staff, there were accounts of verbal humiliation, and the adolescents’ knowledge about their own bodies were disregarded, especially in relation to labor pains [15].

Another aspect that merits attention is that of going from hospital to hospital during labor, which could lead to serious risks for the mother and the baby. Many adolescents reported having to change hospital due to a lack of beds; and so, in addition to not being able to deliver the baby in the hospital they had planned for—as the law stipulates— and in addition to suffering from uncertainty about the unknown, there were also risks of possible consequences to their health.

One aspect that came to our attention is the difference in the delivery experience for pregnant women aged 15–19 and for those older than 20. Although the country is undergoing an epidemic of scheduled caesarian sections—which creates risks for the mother and the baby—we note that, in the city of São Paulo, between 2007 and 2017 the most common form of childbirth for women between 15 and 19 was vaginal (73.3%) [22].

We also noted that during the course of this period, these trends remained steady for both groups. Among pregnant women older than 20, the proportion of cesarean sections not only remained higher than 50% during the course of this period, but it also rose between 2007 and 2013, after which it again declined (**Figure 8**). Among pregnant women aged 15–19, vaginal birth remained close to 70% during this entire period, and in 2015 began to climb, reaching 73.3% of births in 2017 (**Figure 9**).

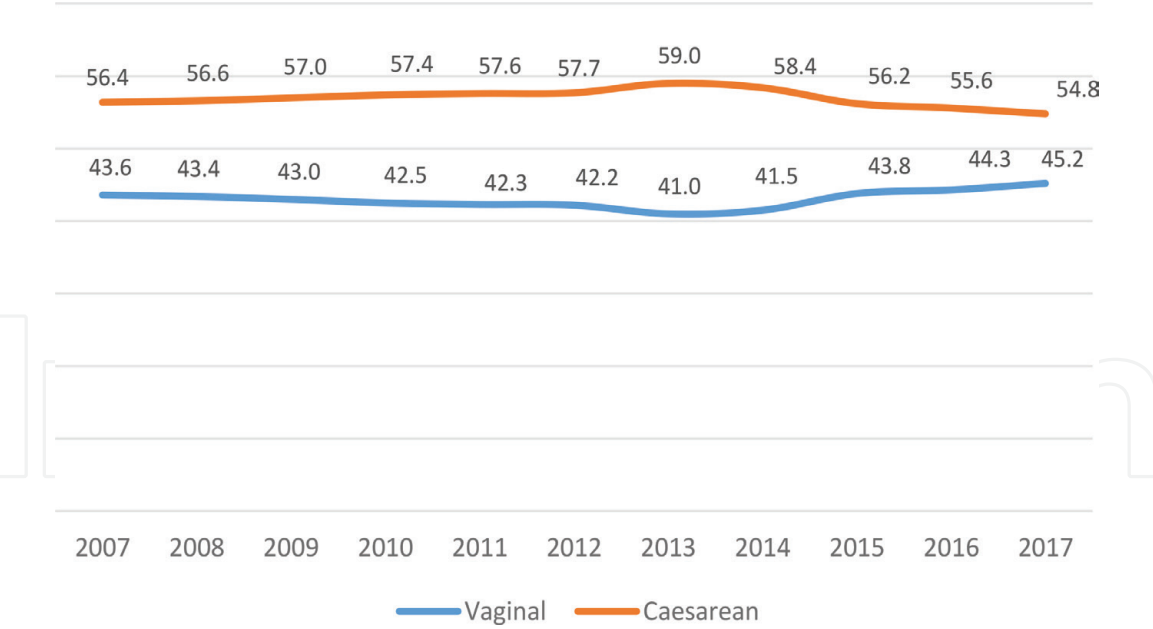


Figure 8. *Cesarian births × vaginal births for pregnant women older than 20, between 2007 and 2017 in the city of São Paulo. Source: DATASUS/TabNet/Municipal Health Department of the City of São Paulo/Accessed Jul 16, 2018. Organized by: Centre for the Study of Violence of University of São Paulo.*

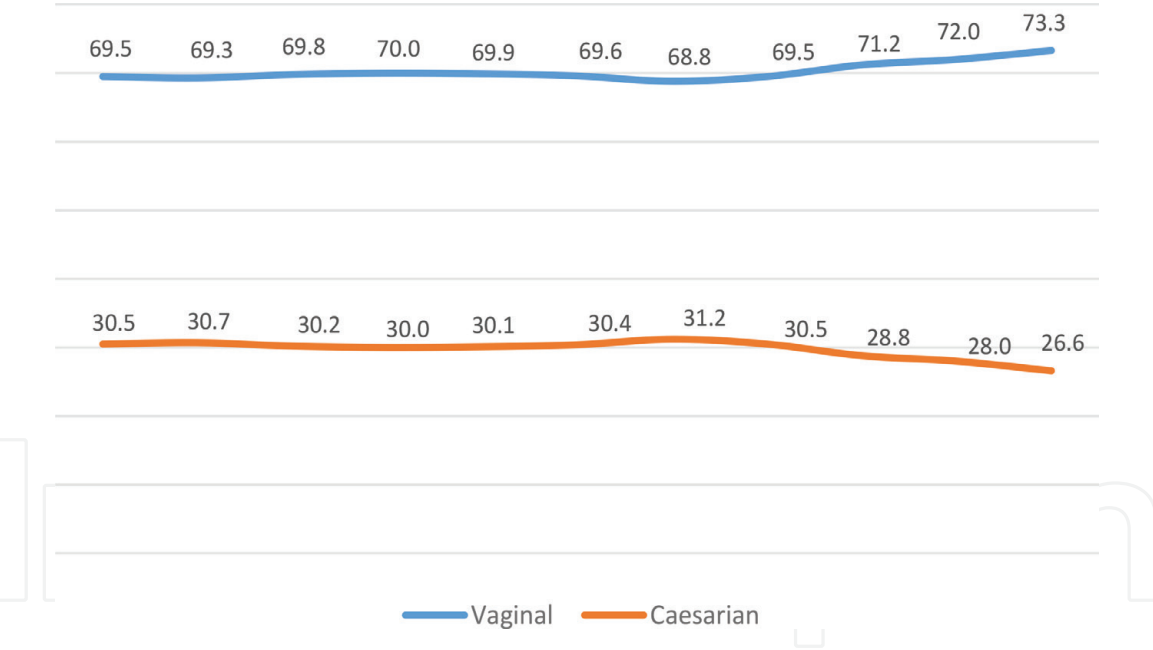


Figure 9. *Cesarian births × vaginal births for pregnant women aged 15–19 years, between 2007 and 2017 in the city of São Paulo. Source: DATASUS/TabNet/Municipal Health Department of the City of São Paulo/Accessed Jul 16, 2018. Organized by: Centre for the Study of Violence of University of São Paulo.*

Unlike what happens in the city as a whole, vaginal births were the most common form of birth in Jardim Ângela, for both age groups. In 2017, the rate of vaginal births was 55.6% for women older than 20, and 76.1% for women aged 15–19 years. This difference reinforces what studies have already shown about the difference in public and private services in terms of choosing the delivery method, in that at some private hospitals the rate of C-sections surpasses 90%. Because we are dealing with a poor peripheral district of the city, with little access to private services, the rate of vaginal births is higher than for the rest of the city.

4.4 Accompaniment of child development

While there were few difficulties in receiving prenatal care, the same cannot be said for accompaniment of the baby. It was very common for adolescents in the project to mention that they had difficulties scheduling the child's routine visits to the doctor, and a lack of pediatricians present at health posts [15].

During the course of the visits it was also very common for the adolescents to complain about not receiving guidance about the development of their children, with no knowledge about forms of stimulating their development and many questions about whether their child's development was normal for their age—at how many months should the child start crawling, walking, talking, etc. The consultations were focused strictly on anthropometric measures and more serious health problems, with no focus on promoting holistic development, which would include an eye for the development of motor, cognitive, and socio-affective skills [15, 27].

In this sense, one of the main focuses of the Health Infancy project was precisely on discussing with the adolescents what they should expect during each phase of their child's development, and what kind of activities could stimulate their child, while also stressing that each child has their own pace of development [23].

Another aspect that led to many questions was in regard to children's feeding habits, an essential aspect for healthy childhood development but one which was little discussed in routine visits. Theoretically, this subject should be discussed as soon as prenatal care begins, because the mother's eating habits will directly affect the way that she will feed her child.

5. Conclusions

We note that in recent decades, governments—together with society—have been making a concerted effort to improve services to mothers and children. Between the period of 1990 and 2015, Brazil reduced the maternal mortality rate by 56%, to 62 deaths per 100,000 births, from 143. And the infant mortality rate dropped to 13 per 1000 live births, from 62 during the same period [22].

Despite progress, the levels of mortality are still high when compared with other countries that have similar levels of economic development. Therefore, it is increasingly critical that Brazil's public policies include integrated actions, and not isolated and verticalized measures, in order to effectively promote maternal-infant health.

Universality, equity, and integrality are the guiding directives of the SUS. However, access to health services and activities are not always guaranteed to everyone, and it is even more difficult to access services that meet the specific needs of the population and take into account all dimensions of the individual.

In this sense, it is necessary to continue investing in the creation of health policies and services capable of meeting real needs, capable of encouraging social opportunity, and capable of reinforcing women's autonomy and the rights of children and adolescents.

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