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Situations of Obstetric Violence from the Perspective of Puerperal Women

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Abstract*— *To investigate situations of obstetric violence in the perception of puerperal women in a teaching hospital. Descriptive study, with a qualitative approach. Data collection used a semi-structured interview with 17 puerperal women. The puerperal women's statements were transcribed and analyzed through content analysis in the thematic modality proposed by Bardin. From the analysis of the statements, four thematic categories emerged: 1) Disrespect for the parturient, 2) Obstetric violence, 3) Violence revealed, 4) Unknown violence. The study revealed the need for changes in childbirth care to make is more welcoming, with pregnant women's protagonism, respecting their rights constituted by laws, and using good obstetric practices for a humanized childbirth free of violence.

Keywords*— *Gender-Based Violence, Midwifery, Nursing, Qualitative Research, Women's Health.

I. INTRODUCTION

The historical analysis of how women experienced their deliveries shows that there were changes in the whole process, with records showing that, in ancient civilizations, women performed their deliveries alone, at most, accompanied by a maternal figure who offered them protection, which would later come to fruition as midwives. This fact culturally sedimented the delivery in the home itself, happening as a natural, private and family process in which the woman was the protagonist of the parturition process [1].

Since the 1940s, the institutionalization of childbirth intensified, aiming to reduce maternal and neonatal mortality and, at the end of the last century, more than 90% of deliveries occurred in the hospital environment. The woman ceased to hold the lead role of her labor, being subjected to seemingly safe norms and interventions, without her consent or oppression, fear, shame and because of the idea that the hospital environment would provide the best care for her and her baby. Assisted by unknown people, away from their relatives and belongings, without the right of choices, contributing to maternal and neonatal risks [1].

To improve obstetric care, the World Health Organization (WHO) published a handbook in 1996, with practices based on scientific evidence called good practices for childbirth care. Ambulation, spray bath and immersion, lumbosacral massage, muscle relaxation, vertical positions, horse method or pelvic movement, aromatherapy, music therapy, Swiss ball, breathing exercises and the presence of a companion chosen by the parturient act in reducing the period of labor, effectively reduce pain and relieve anxiety,

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bringing a physical and psychological comfort to the woman. Thus, they should be inserted in childbirth care [2,3].

On the other hand, procedures such as enema, trichotomy, prophylactic venous catheterization, supine and lithotomic position with or without stirrups, rectal examination, routine uterine washing, prolonged and directed pull effort, massage and distension of the perineum, parenteral ergomethrin and use of radiographic pelvimetry should not be used because they are harmful or ineffective. Early amniotomy, maneuvers related to perineum protection and cephalic pole management, active manipulation of the fetus, early clamping of the umbilical cord, fasting, routine episiotomy and active management of oxytocin labor should be carefully used, since there is no scientific evidence for their use [4].

However, even with scientific evidence supporting the implementation of good practices during labor and delivery, many women experience situations of violence. Exposed through negligence in care, social discrimination, verbal aggression and physical violence, including the non-use of analgesia when indicated, inadequate use of technology, with unnecessary interventions and procedures before the scientific evidence of the moment, causing interventions with potential risks and sequelae [5].

Although in Brazil there is no specific definition of obstetric violence, it is characterized by the appropriation of the body and reproductive processes of women by health professionals, through dehumanized treatment, abuse of medicalization and "pathologization" of natural processes, causing the loss of autonomy and ability to freely decide on their bodies and sexuality, negatively affecting the empowerment of their life and their choices [6].

Thus, the woman has the right to choose the type of delivery, intervention and procedure to be performed, to know their reasons, risks and benefits, to know the possibilities of analgesia and to choose the place of delivery and a companion. These measures should be taken consciously, taking into account maternal and fetal well-being and the autonomy of the parturient [4-6].

Due to the frequent discussions on the theme of social relevance, as it constantly occurs, implying violation of the rights of parturients, evidencing the need for improvement in the attention given to delivery and birth, highlighting the importance of the active participation of women in this context. Thus, this study sought to investigate situations of obstetric violence from the perspective of puerperal women at a teaching hospital.

II. METHODS

This is a descriptive study with a qualitative approach, conducted in a university hospital in Recife/PE, Brazil. The participants were 17 puerperal women, aged over 18 years, in the immediate postpartum period. Submitted to normal delivery or cesarean section of the said hospital and hospitalized in the rooming-in accommodation at the time of research. Those with psychiatric disorders and who gave birth to stillborn fetuses were excluded. The number of interviewees was determined by theoretical saturation during data collection and analysis. The theoretical saturation was identified from the non-occurrence of new information, by the decreasing yield during the content analysis performed [7].

For information collection, a semi-structured interview guide was used, containing the guiding questions: Can you tell how your labor and delivery was? What did you find more difficult about your delivery? Have you ever felt disrespected or mistreated? This guide also had sociodemographic and obstetric issues collected from medical records. Data collection occurred between April and September 2015. An MP3 recorder was used to record the interviews, simultaneously with data collection.

The interviews were fully transcribed. Information was analyzed using the content analysis in the thematic modality, proposed by Bardin [8]. Constituting the following thematic categories: disrespect for the parturient, obstetric violence, violence revealed and unknown violence. The thematic categories were analyzed and interpreted according to the theoretical framework of childbirth care anchored in the World Health Organization [WHO] (1996) [2]. Data related to sample characterization were typed and analyzed in the Software SPSS (Statistical Package for the Social Sciences), version 21.0, using descriptive analysis techniques.

The research occurred after approval by the Research Ethics Committee (CEP) at the Health Sciences Center (CCS) of the Federal University of Pernambuco (UFPE), (CAAE: 40024514.5.0000.5208) and signing of the Informed Consent Form (ICF) by the interviewees. To maintain anonymity, the interviews were identified by alphanumeric codes, using the letter P and subsequent interview number, from 1 to 17. The study respected the formal requirements contained in national and international standards regulating researches involving human beings.

III. RESULTS

The interviewees were between 18 and 44 years old, with an average age of 26.29 years, 70.6% were from the

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Metropolitan Region of Recife and 29.4% from other cities in inland Recife. The majority lived in consensual union (52.9%), only 29.4% were unmarried and 17.6% were married. Regarding education, 17.6% had incomplete elementary school, 17.6% had complete elementary school, 23.5% had incomplete high school, 11.8% had complete high school, 5.9% had incomplete higher education and 23.5% had complete higher education. About the profession/occupation, 58.8% were housewives and 41.2% had paid activity. Regarding monthly family income, 5.9% lived with less than one minimum wage, 47.1% with a minimum wage, 35.3% with two minimum wages and 11.8% with three minimum wages.

Obstetric data, number of pregnancies ranged from one to five (mean=1.94), to one to four deliveries (mean= 1.71), abortions from zero to one (mean= 0.24). Gestational age ranged from 35 to 41 weeks (mean=39.12). The number of normal deliveries was 76.5%, with the remaining 23.5% submitted to cesarean section. The university hospital was the first choice for 41.2% of women. The presence of a companion was reported by 52.9% of the women, 52.9% walked during labor. All patients who gave birth by normal route stated that they were in lithotomy.

The use of oxytocin occurred in 76.5% of deliveries, amniotomy was performed in 52.9% of the women, 70.6% of the interviewees remained fasting throughout the labor, 17.6% used misoprostol and 52.9% received guidance on the procedures performed. The partogram was opened during labor and delivery care of only 17.6% of the women. Care was provided by obstetricians (94.1%) and by obstetric nurses (5.9%).

From the speech analysis, four thematic categories emerged: 1) Disrespect for the parturient, 2) Obstetric violence, 3) Violence revealed, 4) Unknown violence.

Disrespect for the parturient

Good obstetric practices guide professionals to what should and should not be done during labor. Some of these practices were not considered. Starting with the pilgrimage while seeking a place that leads pregnant women feel anxious and disrespected: *First I went there, I thought it was going to be there, the birth... Then they transferred me to another hospital, then there was no duty, no, it was full, then I came back again... And they sent me to (another maternity), so I was hospitalized there. Then the girl came and said that I was going to be transferred to another hospital because there was no anesthesiologist, then they sent me here* (P5). *I got there, they had no place for me there* (P6). *The hardest part was the uncertainty of migrating from one hospital to another, so I felt disrespected* (P9).

The parturients' statements showed that the non-respect of the woman's choice over her companion during labor and delivery contributed negatively to the delivery process. Only the female companion's was allowed in some cases, and her presence was limited only to labor, in a few cases, during vaginal delivery. In cesarean section, this right was denied to pregnant women, whose main argument was the lack of adequate clothing: *One, I don't know if she was a student too or a nurse, I don't know, I just know I asked if she (mother) could get in, so she said, "There's no cloth for me and I work here, imagine for a companion." Then my mother did not get in, I entered the delivery room alone* (P17). *At no point did he (husband) come in to see me because they did not let him* (P11). *My mother wanted to watch the birth... The boy's father also stayed outside because he could not watch, because they had no clothes for either of them* (P13).

The following statements reveal the disrespect to the woman's right to have her privacy preserved in the place of delivery, being subjected to several procedures with the presence of several people, without her prior consent, without the right of refusal, exposing her, making her the object of learning, violating her intimacy: *Two (students), the doctors were all near me, the boss and the doctors, they were all over me* (P2). .. *Many academic doctors, interns, everyone around me, and we are already nervous* (P15). *There were about ten people in the delivery room* (P13). *Many doctors came up to me, examined me and everything* (P8).

Although known as an effective method in relieving pain and anxiety during labor, simple and low-cost therapy, non-pharmacological practices were not used, or were inadequate, hindering labor, coping with pain, generating a sense of death: *They just told me to sit on the ball, there is no professional... what to do on the ball? Do I sit down? Do I jump? Do I walk? I was in so much pain that I do not even like to remember. (Crying) This was the whole night, the pain increasing and they only came to make the touch exam* (P11). *I do not ever want to have a child in my life again. Oh, my God! It was a terrible feeling! I thought I was going to die there. There was so much pain, so much pain. I did not know what that pain was like, first son. You do not know what it is like, you get lost. Because you think it is death, that pain, but I got it, I do not know how, but I did it* (P17).

Another practice reported was the restriction of food and liquids imposed by professionals, a procedure that was not questioned by pregnant women. Regardless of the

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delivery route, the woman's desire and the labor stage, the restriction still extended to the first two hours after vaginal delivery: *Very hungry, it was very difficult for me ... only IV, it was very difficult. Here, I think that is where I had the most accurate guidance that I could even eat, but eating could make me suffer more... Then I followed what they told me* (P9). *Then I asked to drink water, she (professional) said I could not, then I put just a little bit of water on the lips and that was it* (P12). *I could not eat. I only ate two hours after delivery when I got to the infirmary* (P14).

Obstetric violence

Vaginal touch is part of the obstetric evaluation, but should not be performed repeatedly or frequently, especially by more than one professional, being important to guide the woman on the examination, request her authorization and perform in order to minimize the discomfort of the procedure: *They (professionals) always came to make the touch test* (P1). *There came another one to make the touch. Then I said: Are you making the touch test, I cannot take it anymore... It was hurting. It is horrible.* (P7). *Finger has no camera, so they were in doubt, one got in, got out, another got in, got out, one passed to another three, it seems it is two, four: You are playing with my uterus!* (P11).

The use of the oxytocin synthetic hormone to correct or accelerate the pattern of uterine contractility during labor was used deliberately, not respecting the physiology of childbirth, with absence of pain as the main justification for its indication: *They gave me an IV, a medicine* (P8). *I was given an IV to speed up the pain.* (P10). *I was not in pain, then the girl gave me an IV, so I started to feel pain, you know?* (P7). *They started putting medication on me to get to contractions* (P3). *They gave me an IV* (P16).

Routine amniotomy should not be performed in obstetric practice, since there is no scientific evidence that it improves outcomes, yet it is still a very common practice in obstetrics as evidenced in the following reports: *(The doctor) said I was five centimeters, then she broke my water* (P13). *The doctor said I was seven centimeters but the water had not broken, then she grabbed a thing (amniotomo), she broke herself* (P8). *They broke my water in the delivery room* (P3).

We can observe the use of perineum distension during the second stage of labor, a totally harmful practice that further increases the suffering and pain of the parturient and brings no benefit: *They opened the vagina as much as they could, because they were seeing the hair, "That's the hair.", had not crowned yet,... tried, tried, tried, nothing, several times this, suffering was immense, the physical pain was inexplicable, unforgettable* (p15).

Violence revealed

In these discourses, the report of the excess of procedures configured as maltreatment and obstetric violence timidly begins to emerge. In this speech, we can perceive the team directed only to the care of the fetus, not taking into account the feelings and emotions of the parturient: *The team that met me was terrible, because they mistreated me, they were careless, because you're out there screaming, bleeding and they're just listening to your baby's heart and you don't count, don't you?- cry -... I was so angry. You have to learn more, go back to school, because in addition to making money, you have to love what you do, because first of all I think you have to have love and compassion for the patients... You are inhumane. It was perverse, it is like you are nobody, that was my anguish... I was already calling him (husband): Look, come get me, because, if I have to die, I would rather die at home* (P11).

Taking the pregnant woman to the delivery room and not waiting for the physiological time for birth entails a cascade of interventions, transforming the natural moment into something painful, the parturient has no autonomy over her body, feels violated, with psychological sequelae that need to be worked to reduce the damage in future pregnancies: *My problem was in the delivery room, which characterized obstetric violence... let' give her more IV... Open my vagina and I force to see if the baby crowned and nothing, then the obstetrician decided they would do the following: "I'm going to press your belly, it is going to open your vagina, you are going to push... Then the doctor was pressing here, here in the belly... Then he pressed a lot, and his physical condition so strong, a lot of force, right?... Suffering this violence, all over my body, he did that several times and nothing. Then the doctor grabbed the forceps and gave me more IV ... For me, it was abnormal, it was not a normal delivery, my baby was removed, like a caesarean... Feeling mistreated... I was scared. Now, I will never have a child through normal delivery again, by god's will, my next delivery will be a scheduled caesarean. So, it characterized an obstetric violence for me* (P15).

This report unveils the woman's dissatisfaction with the place of delivery, the procedures performed and the team's unawareness that provided the care, even though she accepted the interventions without questioning. Professionals must introduce themselves, ask for the consent of pregnant women and give them the opportunity to decide freely and consciously: *They made the touch test,*

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then they said I was going to be hospitalized, they put me in room two there, then I waited until the doctor came to give the pill, I stayed there a long, long time. For me, I would not have even come here, but was already here right? Do what? I did not like it at all. They took too long and some people had no idea about anything, they were interns I guess. They kept asking the doctor how to do or not to do, I did not like it at all. I kept my mouth shut because I was already feeling a lot of pain, so I let it go... They told me to lie on the bed there, then when she left, they also used the speculum, it hurt so much, they kept poking and poking ... A little disrespected, got it? (P6).

Unknown violence

Although the puerperal women reported having experienced situations of disrespect to good practices of childbirth care, some of them characterizing obstetric violence, it is evident the unawareness of the subject and the lack of association of interventions suffered when questioned about disrespect and maltreatment during their labor and delivery: *Not at all* (P1). *No, not at all* (P2). *No, no* (P3). *No, never* (P4). *No* (P5). *No, I did not feel it, no* (P7). *I have nothing to say, no*. (P8). *No* (P10). *No, no, thank God, no* (P13). *No, never* (P14).

IV. DISCUSSION

This study reveals that all women underwent some type of intervention during labor, and, although most classified as being at usual obstetric risk, they did not experience a natural delivery. The use of technology when well indicated improves obstetric indicators, but if used unnecessarily implies greater risks for women and the conceptus [9]. For this reason, its use must be supported by the updated scientific evidence.

A factor that can contribute to reducing unnecessary interventions is the work with greater autonomy of the obstetric nurse in the delivery room, because he/she plays a more appropriate role, presenting a better cost-effectiveness in the care of pregnancy and normal delivery, assessing risks and recognizing complications [3,9]. Having been supported by the Ministry of Health through Ordinance N. 2815 of 05/29/1998, which included in the Hospital Information System (SIH/SUS) table the procedures for normal delivery without dystocia performed by obstetric nurses and Ordinance GM N. 163 of 09/22/1998, which regulated the performance of normal delivery without dystocia by an obstetric nurse in the Public Health Organizations of the Unified Health System (SUS).

However, in this hospital, the difference in care was not perceived, given the excessive number of unnecessary procedures, even being a high-complexity institution, nurses could better assist labor. All professionals who assist women should have their behaviors supported by the updated scientific evidence. Encouraging pregnant women to have autonomy in the process of parturition, sharing care and respecting their choices. Starting with the right to give birth in the place they want. However, we recognize that the guarantee of these rights is not only linked to the professional who works in the delivery. The lack of structure and professionals in our maternity hospitals results in closed shifts and overcrowding, increasing the pilgrimage of pregnant women seeking a place to give birth, generating feelings of disrespect and anxiety. This violates what must be ensured, the right to know and have access to the maternity where she will receive care at the time of delivery. And when necessary, be referred, having her transport and place guaranteed [1,5,10].

Health services need to adapt to comply with what is exposed in Law n. 11,108 of April 7, 2005, which guarantees parturients the right to the presence of a companion during labor, delivery and immediate postpartum [4]. It is important to emphasize that the companion is chosen by the woman and should be accepted without distinction. His/her presence increases the chances of spontaneous vaginal delivery, decreases intrapartum analgesia and dissatisfaction, promotes shorter labor time, provides lower rate of cesarean section or instrumental vaginal delivery and decreases the chances that the baby has a low Apgar score in the fifth minute of life [10,11]. This right needs to be respected by the institutions in an integral way, denying because of the gender, restricting the companion to labor, allowing permanence only in one type of delivery, preventing access and permanence claiming failure in the physical structure, lack of clothing or under any pretext are violations of an acquired right, contributing to obstetric violence.

The parturient has the right to be assisted throughout her labor and delivery, observing her physical and psychological well-being, including respect for her privacy and the non-permission of unnecessary people in the delivery room. Performing procedures for teaching purposes without considering the integrity and intimacy of the patient causes obstetric violence [5]. According to the reports of our study, pregnant women were seen by several different people during their hospitalization, but they still spent most of their time alone, without adequate care. Making childbirth a painful event and an unpleasant experience.

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Even though labor is generally painful, each woman responds to pain differently, suffering cultural, family, emotional influences, previous experiences and the social group surrounding her. Some describe this pain as terrible, death-like pain, preferring not to remember. The professional who assists the pregnant woman is responsible for providing conditions for her to support the discomforts of the parturition process [11]. This support can be offered through non-pharmacological pain relief techniques, such as immersion bath, shower, massage and aromatherapy, techniques that have demonstrated decreased perception of pain and anxiety. Freedom to take the most comfortable position and ambulation are practices that do not pose risks, so they can be recommended [11]. Activities not performed with most participants since study, even with a multidisciplinary team present in the delivery room.

The incentive and freedom of choice of women over positioning during labor and delivery and the adoption of vertical positions bring physical and psychological benefits and reveal greater satisfaction with the experience of childbirth [9]. Contrary to this recommendation, all the women interviewed reported not having chosen the position and gave birth in a lithotomy position. It reveals the preference of professionals for horizontalized delivery, with technology in favor of their comfort, failing to consider what is best for women.

Another factor that should be considered is the supply of liquids and soft diets during labor, as it contributes to the replacement of spent energy sources, besides preventing dehydration and ketosis, ensuring the well-being of the parturient and the conceptus [12]. However, fasting is still a common practice, as justification for the risk of aspiration of gastric contents, if pregnant women need the use of general anesthesia. To avoid this restriction, it is important to make an evaluation and, in case the pregnant woman is at usual risk, there is no need to prescribe fasting [12]. However, considering that the practice of offering food during labor is recent and many professionals guide fasting fearing complications, we understand why these pregnant women are afraid to eat, demonstrating that they are not being adequately oriented, which prevents them from choosing consciously, without fear or doubts according to their willingness to eat or not. It also reveals the failure in the care of women in the pregnancy cycle, because this information should be passed on during prenatal consultations, where there is continuous contact with the professional and reinforced during their hospitalization.

A finding that deserves attention was the low use of partogram in the deliveries investigated, which is a graphic instrument that allows monitoring the progress of childbirth, being a simple and effective tool that helps in taking appropriate behaviors. In developing countries, its proper use is related to less indication of cesarean sections and early identification of complications [11-12]. It should be adopted in the follow-up of hospital deliveries throughout the public network on the recommendation of the WHO and in the private network through Normative Resolution n. 368/2015. We observed that professionals used techniques such as oxytocin and rupture of amniotic membranes to accelerate labor in more than half of women, which should not be routinely used. The use of oxytocin, for example, in usual-risk women should be avoided, and may lead to complications and the greater need for surveillance of pregnant women [11]. The pain of labor is already intrinsic for many women who do not question these behaviors believing that their routine practice makes them absolutely essential.

In the care of the second period of labor, the directed pull was widely used in order to reduce the time of delivery. Nonetheless, its practice is not recommended, as it is more likely to lead to instrumental delivery, and may injure the pelvic floor. Although parturients regarded it as something inherent in childbirth, it clearly causes physical wear and discomfort. On the other hand, practices such as perineal distension, which should not be performed, episiotomy and forceps use, which should be observed regarding their need and cannot be routinely used, were reported by women within the context of violence. In addition to the reports within the context of violence on pressure at the bottom of the uterus (Kristeller maneuver), for which there is insufficient evidence to recommend or not its use [12], but which made it clear that the way it was applied should not be performed.

Obstetric violence revealed through the excess of unnecessary interventions, and practices not based on scientific evidence updated during labor, delivery and postpartum is a matter of public health. In Brazil, according to a national survey conducted in 2019, (12.6%) women reported having suffered obstetric violence [9]. In the present study, all women suffered some kind of disrespect, including procedures considered violence. However, most of them showed no knowledge of the subject. In order to typify and reduce obstetric violence in the country, law n. 7633/2014 is under process, which provides for the humanization of care to women and newborns during the pregnancy-puerperal cycle and provides other measures [13]. The urgency of dealing with this issue is widely notorious, because, despite the efforts of WHO and the Ministry of Health, with initiatives such as *Rede Cegonha*, there is still much to be done when it comes to humanization of childbirth [14].

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The participants of this study had a good level of education, even though the majority did not recognize obstetric violence, situations of disrespect and the excess of procedures performed with them, all considered as common to labor, making it necessarily laborious and exhausting. The lack of information makes the woman vulnerable, without autonomy to decide freely on her body. The unequal relationship between the professionals who assisted them is noticeable, not being asked to actively participate in the parturition process. This professional attitude needs to be modified, however, it is necessary to change the way in which these professionals learn to approach women in the process of parturition. To eliminate violence, there must be a continuous educational process encompassing professionals who provide assistance directly and indirectly to women and family members. Institutions also must fulfill their role, adapting the infrastructure and making the place of birth a welcoming environment.

V. CONCLUSION

This study showed that, although some women recognize that they were disrespected during their labor and delivery, they still do not associate this disrespect with obstetric violence, believing those practices as common during care, although they cause pain and anguish, supporting, not starring their deliveries.

Despite the several initiatives seeking humanized care, without unnecessary interventions, respecting the intimacy and autonomy of parturients, there is still need to move forward, with health education actions, policy creations, laws, debates in the media, in academic centers, emphasis on prenatal care, to broaden the understanding of the importance of birth humanization.

This work is expected to raise reflections about the need for broad discussions on obstetric care, directing care to women and their families in an integral way, making them autonomous to actively participate in the parturition process, and that good practices be carried out during labor, eliminating obstetric violence.

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