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REFLECTIVE ANALYSIS ARTICLE

OBSTETRICAL VIOLENCE AS PRACTICE IN HEALTH CARE TO WOMAN DURING LABOR: REFLECTIVE ANALYSIS

A VIOLÊNCIA OBSTÉTRICA COMO PRÁTICA NO CUIDADO NA SAÚDE DA MULHER NO PROCESSO PARTURITIVO: ANÁLISE REFLEXIVA

LA VIOLENCIA OBSTÉTRICA COMO PRÁCTICA EN EL CUIDADO DE LA SALUD DE LA MUJER EN EL PROCESO DE PARTO: ANÁLISIS REFLEXIVO

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ABSTRACT

Objective: to promote the reflection of concepts on obstetric violence against women during the childbirth process developed by health services and professionals. **Method:** reflective study, performed from reading of articles and manual. The search for information was made in April 2014 by online access. After reading and recording the literature, we proceeded to descriptive analysis, which contributed to the reflection on obstetric violence. **Results:** we sought to understand the institutional practices characterized as violent, enabling debate grounded on public policies of labor and birth, in addition to human rights and sexual and reproductive rights to women's ransom in the birth scene. **Conclusion:** we emphasize the importance of health professionals in promoting empowerment of women in labor and delivery and also respect for the right to choose practices that are critically employed according to their eligibility criteria, which are based on scientific evidence. **Descriptors:** Nursing; Normal childbirth; Obstetrics; Violence.

RESUMO

Objetivo: promover a reflexão de conceitos acerca da violência obstétrica durante o processo parturitivo contra as mulheres desenvolvidos pelos serviços e profissionais de saúde. **Método:** estudo reflexivo, realizado a partir da leitura de artigos e manual. A busca de informações foi realizada em abril de 2014, pelo acesso on-line, e após a leitura e fichamento da literatura, procedeu-se a análise descritiva, o que contribuiu para a reflexão sobre a violência obstétrica. **Resultados:** buscou-se entender as práticas institucionais caracterizadas como violentas, possibilitando uma discussão respaldada nas políticas públicas do parto e nascimento, além dos direitos humanos e dos direitos sexuais e reprodutivos para o regaste da mulher na cena do parto. **Conclusão:** enfatiza-se a importância de o profissional de saúde promover a autonomia da mulher no trabalho de parto e parto, como o respeito ao direito de escolha de práticas criticamente empregadas conforme os seus critérios de elegibilidade, os quais estão respaldados em evidências científicas. **Descritores:** Enfermagem; Parto Normal; Obstetria; Violência.

RESUMEN

Objetivo: promover la reflexión de conceptos acerca de la violencia obstétrica durante el proceso de parto contra las mujeres desarrollado por los servicios y profesional de salud. **Método:** estudio reflexivo, realizado a partir de la lectura de artículos y manual. La búsqueda de informaciones fue realizada en abril de 2014, por acceso on-line, y luego la lectura y registro de la literatura, se procedió a análisis descriptivo, lo que contribuye para la reflexión sobre la violencia obstétrica. **Resultados:** se buscó entender las prácticas institucionales caracterizadas como violentas, posibilitando una discusión respaldada en las políticas públicas del parto y nacimiento, además de los derechos humanos y de los derechos sexuales y reproductivos para el rescate de la mujer en la escena del parto. **Conclusión:** se enfatiza la importancia del profesional de salud promover la autonomía de la mujer en el trabajo de parto y parto, como el respeto al derecho de elección de prácticas criticamente empleadas conforme sus criterios de elegibilidad, los cuales están respaldados en evidencias científicas. **Descritores:** Enfermería; Parto Normal; Obstetricia; Violencia.

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INTRODUCTION

Pregnancy and childbirth are times inherent in the female life cycle, a physiological process, in which a woman must be the protagonist at all times of these events. Soon, it is for services, managers and professionals to develop and actualize public policies that guarantee the right to quality, integral and humanized care, and that meets the health of women, and of their children.¹

In this sense, the focus of this study is the obstetric violence during the process of labor and delivery based on autonomy and female role, as it contributes to the symbolic cancellation of their rights as a woman, a service user and as a citizen, which runs through the breach of their rights imposed, supported by public policies of labor and birth.

This violence is expressed from negligence in care, social discrimination, verbal violence (rough treatment, threats, reprimands, shouting, intentional humiliation) and physical violence (including non-use of analgesic medication when technically indicated) to the sexual abuse. And also the inappropriate use of technology, with interventions and procedures often unnecessary in the face of current scientific evidence, resulting in a cascade of interventions with potential risks and consequences.²

From this perspective, violence against women is perpetuated in the denial of relief methods to pain, in performing unnecessary procedures without their consent (such as trichotomy, enteroclysis, use of oxytocics, vaginal digital examination, amniotomy and episiotomy), and the neglect, abandonment, indifference to social and gender issues and birth impediment in relation to the vertical position, prevailing the horizontal position, and the annulment of the right to a companion, showing violence by professionals and health services. Similarly, the completion of harmful maneuvers, such as Kristeller, as well as discrimination, coarse treatment with threats, humiliation and ill-treatment with the use of expressions such as "*When you were doing it, you did not cry,*" demonstrate a veiled violence and its naturalization guided by class and gender stereotypes. There should be highlight to the fact that even the sexual abuse can be experienced by a woman,

which constitutes an obstetric violence in public hospitals.³

The theme also makes us reflect on the actual exercise of power and authority of health professionals, especially, physicians in assisting women. Various spheres of public and private sector have mobilized around this question, conducting investigations and debates. The very humanization policy of hospital care and the *Programa de Humanização do Parto e Nascimento* (Program for Humanization of Labor and Childbirth) of the Ministry of Health are examples of responses to the dissatisfaction of users with a treatment denounced as disrespectful, violent and indiscriminate use of technologies that result in high rates of caesarean sections and iatrogenic pain.⁴

Even before this elucidation, today it is clear that such violence permeates the practice of health professionals. Thus, although the concept of Humanization of Labor and Childbirth is recognized and recommended by organizations such as the World Health Organization; the Pan American Health Organization (PAHO); the Ministry of Health; the Brazilian Health System (SUS); the *Conselho Federal de Enfermagem* (Federal Nursing Council - COFEN); the *Associação Brasileira de Obstetrizes e Enfermeiros Obstetras* (Brazilian Association of Midwives and Obstetric Nurses - ABENFO); the *Rede de Humanização do Parto e Nascimento* (Humanization of Labor and Childbirth Network - REHUNA); the *Federação Brasileira de Ginecologia e Obstetrícia* (Brazilian Federation of Gynecology and Obstetrics - FEBRASGO) and also by groups of civil and social debates in favor of women's rights, the birth process is likely to be consisted of violent and inhuman initiatives that disrespect human and reproductive rights of women during parturition.

Latin American countries such as Venezuela and Argentina have law to face the obstetric violence in their country, with measures that protect women from practices and violent situations for their reproductive period. Thus, in Brazil, despite the delay regarding laws that protect women during maternity care, the country has advanced in the reflections and discussions of obstetric violence.

In 2012, due to the shortage of references in Brazilian technical and legal production, it was prepared by the *Rede de Maternidade Ativa* a manual obstetric characterizing violence against women in Brazil during the birth process. Thus, acts characterized as obstetric violence were considered all those committed against women in exercising their sexual and reproductive health, and can be made by health professionals, civil servants, technical and administrative staff of public and private institutions as well as civil, as follows. Thus, obstetric violence can be understood in six different character types: physical, psychological, sexual, institutional, material and from media, which will be identified and discussed in the reflection of this study.

OBJECTIVE

- To promote reflection on the concepts regarding obstetric violence during the birth process against women, developed by health professionals and services.

METHOD

This is a reflective study, supported by systems of references on obstetric violence, developed as a partial requirement to assess the Research Seminar discipline of Master in Science in Health Care of the *Escola de Enfermagem Aurora Afonso Costa* (EEAAC) of the *Universidade Federal Fluminense* (UFF), attended in the first half of 2014, which sought a reflection on this type of violence in the labor and delivery scenario.

For its development, we conducted a narrative review of the literature aiming to gather knowledge on the topics of study, facilitating reflective analysis. The literature included articles and manual. The articles were researched in LILACS (Latin American and Caribbean Health Sciences), BDENF (Nursing Database) and SciELO library (Scientific Electronic Library Online). The full articles were included; available electronically; published in Portuguese, English or Spanish; from 2004 to 2014.

To search for such articles, we used controlled descriptors "violence", "normal delivery" and "obstetrics". The search was conducted by online access in April 2014. After reading and reporting of the available literature, we proceeded to descriptive and content analysis, which contributed to the reflection on the theme.

RESULTS AND DISCUSSION

The *Programa de Humanização do Parto e Nascimento* (PHPN) was established by the Ministry of Health through Ordinance/GM No. 569/2000, with the aim to ensure improved access, coverage and quality in monitoring to prenatal, childbirth and postpartum.⁶ In addition, in 2011, the same government agency promoted the launch of the *Rede Cegonha* program, which has aimed to ensure access to reference units and to safe transport, to ensure the promotion of good practices in care to labor and delivery, for the purpose of reducing maternal mortality, to ensure the 5th Millennium Development Goals.⁷

Despite the commitment of the Ministry of Health to promote quality in delivery care, it is still needed a change in care practices such as protocols established by the health services. This transformation must occur so that woman can experience the birth of their children to their fullest and experience childbirth as an intimate event, safe and without violence, however, this still does not occur, but there is occurrence of practices considered violent, with rules and routines that value professional assistance and not the value of the mothers' experience.

In this context, when the health institution prevents women to have the free choice of their companion during labor, delivery and postpartum, that is is a violence in the *institutional field*, which consists of actions or forms of organization that hinder, retard or prevent the access of women to their constituted rights, whether public or private.⁵ In addition, this type of violence happens by including rules and conducts established by the health service, in this case, the maternity and health professionals that have the instituted authority and the power to authorize or not, being a practical experienced by women in maternity.

Thus, there is disrespect of sexual and reproductive rights, of good practices to childbirth, in addition to breach of Law No. 11,108/2005, which obliges health institutions to allow the presence of a companion free chosen by the women during all period of labor, delivery and postpartum.⁸ Thus, accompanying the labor and delivery should be encouraged by health institutions to promote the support the

woman. The support measures to the woman include four dimensions: emotional (continuous presence, encouragement and providing tranquility); informational (explanations, instructions on the evolution of labor and counseling); physical comfort (massages, hot baths and adequate supply of liquids); and, finally, the intermediation, which has the purpose of interpreting women's desires and negotiating them with professionals.⁹

It is often observed that health professionals prevent women from moving during labor, ordering them to "lie" on the bed for the best progression of labor, and likewise, women are restrained in relation to the spray bath for the purpose of pain relief, besides not offering food and fluids during labor and delivery process, which are institutional practices that break with good labor practices, making them an "object" of health care professionals. Thus, it becomes one of the forms of violence in the *physical field*, because of direct actions that incur to the woman's body that interfere, cause (mild to intense) pain or physical injury, without recommendation based on scientific evidence.⁵

Given the above, the empowerment of women is inhibited as their position and movement during labor, such as the right of bathing during the process. These practices are recommendations of the Ministry of Health and should be implemented for the purpose of better progression of labor and to help to relieve pain. In addition, the incentive to warm water bath brings physical and mental relaxation for the woman, as it promotes the evolution of labor.¹⁰ This point should be discussed, as such practices favor an increase in pain during labor and health professionals should encourage its relief, and not promoting these practices constitutes a type of violence.

Leaving the woman without food and fluids during labor and informing that they need to fast, as a result of any problems during their labor, besides the technocratic model, in that any time a woman can undergo a surgical intervention. And favoring this institutional routine promotes physical violence, besides the right to choice, for the liquid and power supply promotes more energy for childbirth, and needs to be encouraged as recommended by the Ministry of Health.¹⁰

The lack of guidance/information from health care professionals about the methods used and the model of birth establishes a violation of women's rights regarding the relevant information to the labor and delivery as recommended by the World Health Organization (WHO), which is *psychological violence*, caused by the professional-parturient relationship that cancels the right of women. This modality points to every verbal or behavioral action that causes in women feelings of inferiority, vulnerability, abandonment, emotional instability, fear, insecurity, deterrence, delusion, alienation, loss of integrity, dignity and prestige, experienced by the lack of information.⁵

So the obstetrical care in the birth process often is not clear to women because in culture of service based on technocratic paradigm today in force, health professionals are those who "master" the care process, making women submissive to their knowledge and practices, mere "objects" of the knowledge of these professionals, not subjects participating in this process. It is, therefore, a situation that can create tension, fear, insecurity and/or anxiety in women during their hospital stay, and expresses the power and the relationship of the professional who has the instituted power established by the health service. Thus, this lack of information violates the right of women to be informed about the childbirth and about the implemented practices, which constitutes a form of violence in women's psychological field.²

Like, for example, the exposure of their body during the care process without proper ethical attitude of health workers, in which women are exposed to different actors without convenient protection in performing tests such as the vaginal digital test. This attitude experienced by women violates their privacy and constitutes a form of violence, *sexual violence*, which is expressed in every action imposed to women that violates their privacy or modesty, incurring on their sense of sexual and reproductive integrity and may have access or not to sexual organs and private parts of their body.⁵

The classification of practices in normal birth clearly brings those used improperly, considered by the Ministry of Health as harmful or ineffective and therefore should

be eliminated or reduced, among these, these are the frequent vaginal digital tests, carried by more than one professional. It appears that unfortunately this is constant a practice, that is, performing vaginal digital tests more often and by various professionals in small time intervals, which impairs the physiological evolution of the labor and delivery, causing discomfort and vulvar edema. Additionally, this document provides other classifications as useful practices that should be encouraged, considering essential the respect for the women's right to privacy in the delivery place.¹¹

Unlike pointed out about this type of violence, the authors¹¹ point to the *psychological violence*, not sexual, as understood in this study, and they characterize this violence when an individual is submitted to the exposure of their body for the provision of care without safeguarding their privacy and without respecting their cultural and religious values. They add that many workers witness violence and omit or cover up the bully, fearing to attract dislikes and enmities.

The realization of institutional practices, especially, the routine episiotomy, constitutes a *sexual violent*. Besides that practice, performing the Kristeller maneuver is also a form of violence, *physical violence*. These practices are used during childbirth and aim to "help" during the delivery. The use of episiotomy and should be reconsidered and Kristeller maneuver should be abolished.

An episiotomy is a surgical procedure performed on the vulva, cutting the vaginal opening with scissors or scalpel, sometimes without anesthesia.¹²⁻³ It affects various perineal structures such as muscles, blood vessels and tendons, which are responsible for the support of some organs, for the urinary and fecal continence and still have important links with the clitoris. In Brazil, the episiotomy is the only surgery performed without the woman's consent and without she being informed of its need (prescription), its risks, its possible benefits and side effects. The woman is not informed on alternative treatment options, either. Thus, the practice of episiotomy in the country is contrary to the precepts of evidence-based medicine and, according to the scientific evidence, it should be used in about 10% to 15% of cases. However,

episiotomy is practiced in over 90% of hospital deliveries.⁵

Importantly, episiotomy, by itself, constitutes leastwise a second degree trauma. In addition to ignore this fact, often doctors say that not performing this procedure inevitably entails severe lacerations, which also has no scientific basis. Another claim for episiotomy is the prevention of urinary and fecal incontinence, which is not a scientifically proven fact. So far, there are not long-term studies to verify the occurrence of incontinence in older ages of women, relating to the implementation or not of episiotomy. However, studies that include shorter horizons indicate that episiotomy has precisely the opposite effect, of causing or aggravating urinary, fecal and flatus incontinence.^{5,14-5} Thus, the episiotomy without sufficient scientific evidence constitutes violence against women and should be reconsidered during the delivery.

When the Kristeller maneuver was developed without scientific basis, this maneuver was carried out with both hands pushing the woman's belly towards the pelvis. Currently, we have several studies that demonstrate the serious complications of this procedure and yet the maneuver is often performed with a person going up on the woman's belly, or squeezing her womb with the weight of their body on their hands, arms, forearms or knees.⁵ It should be noted that health professionals themselves recognize that Kristeller maneuver is proscribed, however, they continue to carry it despite never registering at the medical record.¹⁶

The Kristeller maneuver is known as harmful to health and, at the same time, ineffective, as it causes discomfort and pain to the woman and also trauma that will accompany her indefinitely.^{5,17} This procedure, besides all damages already presented, constitutes a physical type of violence, and clearly contradicts the recommendations of the Ministry of Health to promote the various positions during childbirth, provided that there are no clinical impediments.

Thus, the birth process in a technocratic model in which women are subjected comprises distinct types of violence. Thus, we must fight against the institutional practices and interventionist birth models in favor of the rescue of women's reproductive

health as the actual role in the childbirth scene.

CONCLUSION

Institutional practices employed during the labor and delivery by healthcare professionals in public hospitals are intertwined in acts of violence in different forms, being *physical, psychological, sexual and institutional* types of violence. Thus, these practices should be reconsidered by health professionals to promote women's reproductive health, implying a change in thinking, values and rules during the act of birth, and reaching its legal value established of sexual and reproductive rights as human rights at birth for women.

Thus, the rescue of the woman figure in the birth scene with respect for their freedom of choice, the clarification of the procedures by health professionals and the selective evaluation of evidence-based practices should be inserted in the routine of health professionals' practice for the safety of women during labor and delivery, in addition to combating violence in the birth scene. In this regard, we emphasize the use of better practices in normal childbirth established by WHO in favor of reducing interventions and rescuing the woman during her actual role in childbirth.

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