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OBSTETRIC VIOLENCE WITHIN THE HOSPITAL ENVIRONMENT: EXPERIENCE REPORT ON INCONSISTENCIES AND CONTROVERSIES

VIOLÊNCIA OBSTÉTRICA NO AMBIENTE HOSPITALAR: RELATO DE EXPERIÊNCIA SOBRE INCOERÊNCIAS E CONTROVÉRSIAS

VIOLENCIA OBSTÉTRICA EN EL AMBIENTE HOSPITALARIO: INFORME DE EXPERIENCIA ACERCA DE INCONSISTENCIAS Y CONTROVERSIAS

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ABSTRACT

Objective: to report the obstetric violence experienced by undergraduate students at pre-delivery sectors and the obstetric center in a state public hospital in south-western Bahia, Brazil. **Method:** descriptive study, an experience report, conducted during the practices of the Curricular Supervised Internship II, by undergraduate students of Nursing at the Bahia State University (UNEB), in April and May 2015, covering the actions observed within the hospital environment that were characterized as obstetric violence. **Results:** situations of physical, psychological, and institutional obstetric violence were observed, reflecting on health problems for women. **Conclusion:** obstetric violence still occurs and it hurts women's autonomy, especially in a veiled way, in a moment of weakness and lack of family social support. Thus, the insensitivity of professionals during childbirth care is noticed, contradicting the childbirth humanization policies. **Descriptors:** Violence Against Women; Women's Health; Nursing; Humanization of Care.

RESUMO

Objetivo: relatar a violência obstétrica presenciada por alunos de graduação nos setores de pré-parto e centro obstétrico de um hospital público estadual no Sudoeste baiano. **Método:** estudo descritivo, tipo relato de experiência, realizado durante as práticas do Estágio Curricular Supervisionado II, por alunos de graduação em Enfermagem da Universidade do Estado Bahia (Uneb), em abril e maio de 2015, abordando as ações observadas no ambiente hospitalar que se caracterizavam como violência obstétrica. **Resultados:** observaram-se situações de violência obstétrica física, psicológica e institucional, repercutindo em agravos à saúde da mulher. **Conclusão:** a violência obstétrica ainda ocorre e fere a autonomia das mulheres, sobretudo de maneira velada, em um momento de fragilidade e ausência de apoio social familiar. Desse modo, nota-se a insensibilidade dos profissionais durante a assistência ao parto, contradizendo as políticas de humanização do parto. **Descritores:** Violência Contra a Mulher; Saúde da Mulher; Enfermagem; Humanização da Assistência.

RESUMEN

Objetivo: reportar la violencia obstétrica experimentada por estudiantes de pregrado en los sectores pre-parto y el centro de obstetricia en un hospital público del estado en el suroeste de Bahía, Brasil. **Método:** estudio descriptivo, un informe de experiencia, realizado durante las prácticas de la Pasantía Curricular Supervisada II, por estudiantes de pregrado de Enfermería de la Universidad del Estado de Bahía (UNEB), en abril y mayo de 2015, que cubre las acciones observadas en el ambiente hospitalario que se caracterizaron como violencia obstétrica. **Resultados:** situaciones de violencia obstétrica física, psicológica e institucional se observaron, repercutiendo en problemas de salud para la mujer. **Conclusión:** la violencia obstétrica se sigue produciendo e hiere la autonomía de las mujeres, sobre todo de una manera velada, en un momento de debilidad y falta de apoyo social de la familia. Por lo tanto, la falta de sensibilidad de los profesionales durante la atención del parto se nota, lo que contradice las políticas de humanización del parto. **Descriptores:** Violencia Contra la Mujer; Salud de la Mujer; Enfermería; Humanización de la Atención.

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INTRODUCTION

Although conception is characterized as a physiological act, sometimes the actions of health professionals, through wrong interventions and techniques, infringe women's participation power and autonomy during pregnancy, childbirth, and puerperium, contradicting the public humanization policies and philosophies that advocate the individual's autonomy. In this way, a woman becomes a professional intervention object and not a subject of her own actions and decisions. Thus, the primary rights guaranteed by the Ministry of Health (MoH) as a humanized, equitable, and holistic care are not always prioritized.¹

Despite humanization is advocated as a crucial part in childbirth care, some practices cause harmful psychological and physical outcomes to a woman's health.² This scenario represents an obstetric violence, characterized by the subordination of women to professional knowledge, practices, and knowledge that seek to control experience of motherhood and it occurs when people exceed scientific evidence for childbirth care, through the abuse of technology in violation of the physiological process. It also addresses the violation of freedom of choice and disregard for human dimensions.³

This kind of violation against physical and emotional integrity has become the subject of great scientific discussions due to the significant occurrence in the country's hospitals. However, there is little information available that address childbirth care, covering procedures and techniques employed during parturition and birth, which do not allow thoroughly quantifying the magnitude of this problem. We emphasize the scarcity of studies that point the prevalence and factors associated to the theme, especially with regard to robust samples and methods.

A Brazilian research conducted by the Perseu Abramo Foundation, in 2012, on the scene of labor and birth, showed that 25% of the women who had vaginal delivery reported having experienced some form of obstetric torment or violence.⁴ This finding confirms the lack of specific and clear numbers, because from this perspective information was identified only through non-formal reports, due to the lack of official notifications of cases.

In addition to this fact, based on research that shows a high number of caesarean sections and dystocia that took place in vaginal deliveries, it may be said that obstetric care in the country has an interventionist nature with a technocratic approach. In 2013, the approximate total number of births in Brazil

was 2,904,027, out of which 1,253,726 were vaginal deliveries and 1,644,557 were caesarean sections.⁵

Although a woman has the right to choose the mode of delivery, receiving comprehensive care during childbirth and having the support of a companion of her choice, generally this scenario emerges in a controversial way, and there are recurrent cases of verbal abuse and maneuvers that result in violence against women.

Among the various situations of violence, the highest incidence within the hospital environment has an obstetric nature, which is an aggression against women's sexual, mental, and reproductive health, and it may be caused by health professionals who work in public and private sectors. These actions cause feelings of inferiority, humiliation, and abandonment at the time of need.²

The most common obstetric violence is psychological, sexual, institutional, and physical. Among them the most recurrent is related to psychological mistreatment by health professionals, expressed as negligent care, rough treatment, repression, roars, and intentional humiliation.¹

Sexual violence is commonly reported and it occurs when a woman's intimacy and modesty are not observed or if there is unnecessarily manipulation of intimate body parts, such as invasive touch tests, constant or aggressive, enema, asking a patient to take the supine position, and repetitive tests on the nipples without any information.²

Institutional violence is exercised by public or private hospital organizations through improper action, omission of information and care, in order to impose unjustified standards or unnecessary requirements. Basically, it occurs in case of unequal power relationships between health professional and patient.¹

The most common examples of institutional violence that occur at the delivery room or the obstetric center are lack of encouragement for early contact between the newborn infant and the mother and lack of breastfeeding. This scenario occurs frequently, despite the MoH advises on the promotion of breast feeding and the benefits of such a practice. Many hospitals do not consider a mother's wish to breastfeed the baby at birth, even without any clinical restriction for this. In cesarean sections this stimulus decreases, since there is an increased practice of artificial breastfeeding.⁴

Another example of this violence is provided by the absence of a companion during labor. Despite the support of Law 11,108/2005, which guarantees the presence of a companion chosen by the woman, some health centers do

not have a physical structure that allows implementing it, inhibiting the presence of a partner at the time of delivery.⁶

Physical violence occurs when injury, pain, or discomfort are directly caused to the woman, without recommendation based on scientific evidence to justify such a practice.⁷ The two most common examples are episiotomy and Kristeller maneuver.

Episiotomy is a procedure to increase the vaginal canal during labor, a practice that should be adopted by professionals in an appropriate and judicious way, promoting protection for the woman and the child, as well as decreased perineal lacerations.² However, some professionals still practice it without woman's consent, there is no information about the actual indications and its complications, such as: excessive narrowing of the introitus, vaginal prolapse, vaginal fistula, increased blood loss, pain, swelling, infection, lacerations, dehiscence, and sexual dysfunction.⁴

Kristeller maneuver is performed when a person is placed over the woman's belly or presses her belly with her/his body weight, using hands, arm, or forearm to press the mother giving birth and help fetal expulsion.⁸

In addition to these procedures that violate the maternal and fetal health, the lack of use of pharmacological therapies for pain relief and practices that provide women with a better development in expansion and labor, such as spray or soak in hot water, massages and movement, are imperceptible.⁷

Other practices also may be used during labor, such as providing the choice of a companion, as well as answering to questions, intermittent fetal monitoring, freedom of position and movement, and partogram.⁹

A study conducted in 2011 in Brazil, with 10,342 women, about the use of good practices during labor, showed that in the Northeastern Region 16.6% were fed during labor; 39.1% had freedom of movement; with 19.1% non-pharmacological methods were adopted for pain relief; with 30.4% of the women labor progress was monitored through a partogram. As for maneuvers and invasive procedures, in 40.6% of births Kristeller maneuver was used and in 52.5% episiotomy was used.⁷

These data reflect how obstetric violence is a major public health problem with high prevalence, despite the lack of formal notification within the national health system, because its incidence still occurs in a veiled way, that is why discussing it becomes indispensable for the human professional training.

A woman must receive information on the conception process, in order to be an active subject, preventing professionals to violate her right of choice and participation. There is a need to change the wrong thinking rooted in the traditional way to perform and see childbirth.

The marks caused by violence go beyond a surgical scar; they provoke feelings that permeate the memory of a moment of fullness and fulfillment, violated by the insensitivity of those who should facilitate the process of comprehensive care to a woman. For these reasons, this study aims to:

- Report the obstetric violence experienced by undergraduate students at pre-delivery sectors and the obstetric center in a state public hospital in south-western Bahia, Brazil.

METHOD

Qualitative and descriptive study, an experience report, experienced by undergraduate students of Nursing at the 10th semester of the course in the Bahia State University (UNEB), attending the discipline Curricular Supervised Internship II.

The reports focused on situations characterized as institutional, psychological, and physical obstetric violence, which took place at the pre-delivery sectors and the obstetric center in a public hospital, located in south-western Bahia, Brazil, in April and May 2015, with a total of 17 deliveries, out of which 9 were vaginal and 8 cesarean sections within 9 days at both sectors.

Such a curricular component of the university aims to provide students with practical experiences and situations of care, seeking to associate theory and practice, in order to stimulate a critical attitude and further development of problem-solving strategies to increase transformative measures of reality. In the meantime, we sought a responsibility to accommodate pregnant women and their companions, clarifying doubts and anxieties, provide comprehensive care from prenatal to postpartum, including all stages of the nursing care systematization (anamnesis and physical examination, nursing diagnosis, nursing planning and prescription, nursing (re)assessment), interpretation of laboratory tests, fetal heart-rate auscultation, and administration of medications according to the prescription.

By understanding that the university plays a major role in this process, undergraduate students and professors in the discipline Curricular Supervised Internship II sought an update on this theme on two occasions, in order to include all professionals from the

health center at that sector. The scale was developed in partnership with the sector's nursing coordination, relying on the participation of most nursing professionals.

The study contextualization was made starting from the reading of articles and documents by the MoH that discussed the themes addressed, found in the database Virtual Health Library (VHL), which comprises the Scientific Electronic Library Online (SciELO), the Latin American and Caribbean Health Sciences Literature (LILACS), and the International Literature on Health Sciences (MedLine) in June 2015, by adopting the descriptors "violence against women," "women's health," and "obstetric violence."

Articles and public health care documents that addressed the concept and types of obstetric violence were sought, as well as assistance to humanized childbirth and feelings of pregnant women during labor, and those that met the following inclusion criteria: being a national public document and/or original article with full texts available online in Portuguese, being in the database VHL, and the sample consisted of 12 articles and 6 public health documents.

RESULTS

In the institution under study some situations of obstetric violence were observed, namely: 1) psychological; 2) physical; and 3) institutional.

Given the above, the first violence against women begins still at the delivery room during the very labor and it is characterized by psychological violence. Most hospital professionals showed insensitivity in assisting women giving birth in pain, and the woman was roughly addressed, in an imposing manner, so that she does not verbalize the pain felt by "crying," in order not to disturb the professional and the other women.

In this experience, situations where the speeches consisted in typical cases of psychological obstetric violence were witnessed.

If you scream and it helps, "little mother," I am going to scream, too.

It is inevitable not speaking: at the time to make no one cries.

Some of them were labeled due to their reaction to pain as "scandalous and someone who likes to draw attention."

In this context, women were often silent, even in pain, due to their fear of suffering even further or being "forgotten" by the professionals when they were in labor. Thus, they kept up silent, seeking not to "make a scene," to ensure assistance.

Physical obstetric violence was the second perceived, and the most common were those characterized by inappropriate use of Kristeller maneuver and episiotomy. The use of partogram has not been observed, and this is a significant instrument to assess labor evolution. The claim for not using it, in some speeches, was "*It is not needed,*" since "*all information is already written in the medical record*" of a woman.

It is inferred that disuse is related to lack of knowledge on the way how to fill it in the right way, since some professionals claimed to have never filled in a partogram and they have not learned to do that during their undergraduate course.

Kristeller maneuver was observed in most births were expulsion and childbirth evolution occurred slowly, according to a physiological condition or because this was the first pregnancy. This maneuver was used because of the hurry to "conclude" the procedure, considering the large flow of surgeries to be performed and the lack of qualification of some professionals.

In addition, episiotomy was another unnecessary procedure commonly adopted for physically assaulting women in a situation of weakness. This technique is used regularly within the hospital by physicians and obstetric nurses, without using analgesia, exposing the woman to a painful procedure, which can lead to complications, in further childbirths, as well as the risk of infections.

The speeches that marked the observation describe expressions typifying cases of physical obstetric violence and, as a consequence, psychological: "*Doctor, what is happening?*" In this situation, the response obtained by the mother was: "*I am just making some 'stitches,' it is almost over.*" Another time, after episiotomy, the professional commented: "She is a relative of the plastic surgeon, he will solve it afterwards."

It is clear that professionals are indifferent to the pain of others, and the holistic view is not always observed. At the time when such techniques become routine and not sporadic situations, it is clear that a woman's body is perceived as subject to manipulation and not as a human being who has autonomy and freedom of choice, in need of respectful and individualized care at that moment.

Institutional violence was the third to be analyzed and it was due to lack of incentive to early breastfeeding, lack of a companion at the pre-delivery sector and the obstetric center and the omission of information about the delivery process.

In good clinical conditions, skin to skin contact and breastfeeding immediately after birth constitute a significant method that provides benefits to the newborn infant and it strengthens the mother-child bond. However, an early implementation of such practices was not noticed, extremely relevant for the development of a child and a woman's health.

Even being recommended by the MoH, the right to choose a companion showed up as a different reality in these sectors, because, as an imposition of the health care facility, the partner should be a woman. The reason given by the health team is that the presence of the spouse might affect the privacy of the other women, because the pre-delivery ward is collective and other pregnant women are there; in turn, at the obstetric center it might be a burden to people in that environment.

These women were not previously informed, by health professionals, about potential complications and which procedures might be needed to solve each case, something which could be a factor that influenced on a woman's fear and stress during labor.

Such violence was reproduced by hierarchy and domination of medical knowledge on a woman's body, directly hurting her autonomy with regard to what belongs only to her: her body.

DISCUSSION

Childbirth is a physiological process that begins and evolves on its own, it may occur comfortably, safely, and without any intervention. From this perspective, an obstetric care based on evidence is that providing assistance, support, and protection, with a minimum of unnecessary interventions.¹⁰

Thus, when analyzing the observations made during the report, insensitivity and lack of preparation were observed in the practice of some professionals that help labor. It is understood as obstetric violence, during labor, every dehumanized treatment where there is abuse of medicalization and pathologization of natural processes, causing a mother to lose her autonomy and ability to freely decide on her body and generating negative impacts on her quality of life.¹⁰

It is emphasized that the health team's comments, previously reported, are rejected by obstetrics, because they generate discomfort and disrespect to a woman's physical and mental integrity. In addition to cause a feeling of inferiority, vulnerability, abandonment, emotional instability, fear, lack of an alternative, insecurity, deceit, alienation, and loss of integrity, dignity, and prestige.¹¹

Kristeller maneuver was used to promote fetal descent through the birth canal, although there is still no grounded scientific data justifying it as a safe practice, thus it is contraindicated.¹² In addition to pain and suffering, there are complications for a woman, such as liver disruption and damage to the newborn infant, such as fractures.¹⁰

Episiotomy was incorporated into routine delivery care from the early 20th century with the intent of reducing the damage caused by natural perineal laceration, reduce the risk of subsequent urinary and fecal incontinence, and protect the newborn infant from the birth trauma.¹²

The choice of this technique should be strict, because when this is a routine, it increases the risks of intraoperative and postpartum complications, such as 3rd and 4th degree perineal laceration, risk of infection and bleeding, without diminishing, in the long run, the complications of pain and urinary and fecal incontinence.^{12,13}

Regarding the acts of institutional obstetric violence, we identified: impediment or difficulty to allow mothers' contact with her newborn infant soon after birth, as well as absence of breastfeeding and a companion in the delivery room, the institution justifies it through the limited physical space of the obstetric center.

Women have a limited right concerning the choice of her companion, something which prevents her partner to participate in this process. The institutional justification for this prohibition is based on the prerogative of a collective female ward, whose patients might feel embarrassed due to the presence of a man. Thus, if a pregnant woman does not have a female relative, she has no companion.

Professionals did not encourage an early contact and breastfeeding within the first hour of life, despite scientific evidence showing that breastfeeding reduces by 22% the neonatal mortality rate due to infections. This decreased death rates takes place because colostrum acts as a protection by being related to several mechanisms, such as intestinal colonization by certain bacteria found in breast milk and its ability to produce bioactive immune factors suitable for the newborn infant.¹⁴

Women's lack of information on the subject was another factor observed. Although Brazil has achieved high coverage in prenatal care and the hospital delivery rate was greater than 98% in 2010, it is observed that these women could be advised from the beginning of prenatal care, still in the Family Health Strategy (FHS), in order to have a better basis concerning childbirth, and especially with regard to the acts of obstetric violence. The

lack of this additional information within the hospital environment exacerbates this profile.¹²

Proposals for reversing in this actual scenario are based on education since the construction of professional identity. Thus, the pedagogical changes in the curriculum are meaningful strategies for addressing violence in services, by requiring transformation of conceptions and practices of professionals, still too focused on the biomedical approach.

It is crucial to provide spaces for updates, reflections, and support for professionals, in order to make them feel able and confident to work with the issue, as discussing at the undergraduate course notions of gender, reproductive and human rights is crucial to guide the positions and practices of prospective professionals.¹⁵

It is clear that Brazil has been engaged in the development of public policies aimed at humanization and quality of obstetric and neonatal care. However, it may be noticed that the humanized practices recommended by the World Health Organization (WHO) and by the Brazilian policies implemented, regarding delivery care, have not been taken into account.¹⁵

The persistence of the traditional model is noticed in practice, where women are subject to hospital routines, deprived of their autonomy in the parturition process and exposed to practices without scientific evidence to support their use, often unnecessary and harmful to maternal and child health.¹⁶⁻¹⁸

CONCLUSION

It was characterized that women provided with care at this hospital health institution were exposed to psychological, physical, and institutional violence, and that most of the health professionals proved to be insensitive to pain before, during, and after childbirth. Therefore, the need to invest in health education by providing these women with instructions in greater detail since the beginning of prenatal care, through the FHS, became clear, so that they have a sound basis in relation to the concept of delivery, can expose their autonomy in claiming their rights, and reduce their insecurity, because passive attitudes contribute to the underreporting of the problem, even if informally.

Knowing the weakness of professionals in addressing this subject is significant, because it facilitates the understanding of the actual scene of some situations of neglect of care. There is a need to fill the gaps in Higher Education, investing in continuing education for professionals in an impactful way, in order to work on mutual respect through empathy in the

professional and patient relationship. This measure of recurrent training may help reduce the obstetric violence rates. Also, recognizing these aspects as obstetric violence, understanding it as a crime against women's health, and, as a consequence, the newborn infant's health, it will allow such violence to be prevented, punished, and eradicated.

REFERENCES

1. Aguiar JM, D'Oliveira AFL. Institutional violence in public maternity hospitals: the women's view. *Interface Comun Saúde Educ* [serial on the internet]. 2011 Jan-Mar [cited 2015 June 6];15(36):79-91. Available from: <http://www.scielo.br/pdf/icse/v15n36/aop4010.pdf>.
2. Ciello C, Carvalho C, Kondo C, Delage D, Niy D, Werner L, et al. Dossiê da violência obstétrica: "parirás com dor" [document on the internet]. 2012 [cited 2015 Aug 10]. Available from: <http://www.senado.gov.br/comissoes/documentos/SSCEPI/DOC%20VCM%20367.pdf>.
3. Pulhez MM. Parem a violência obstétrica! *Revista Brasileira de Sociologia da Emoção* [serial on the internet]. 2013 [cited 2015 June 4];12(35):522-37. Available from: <http://www.cchla.ufpb.br/rbse/PulhezRes%20Copy.pdf>.
4. Brasil. Humanização do parto e do nascimento. Brasília (DF): Ministério da Saúde; 2014. (Cadernos Humaniza SUS).
5. Brasil. DataSUS [document on the internet]. 2015 [cited 2015 June 5]. Available from: <http://www.datasus.gov.br>.
6. Brüggemann OM, Ebsen ES, Oliveira ME, Gorayeb MK, Ebele RR. Motivos que levam os serviços de saúde a não permitirem acompanhante de parto: discursos de enfermeiros. *Texto & Contexto Enferm* [serial on the internet]. 2014 Apr-June [cited 2015 May 10];23(2):270-7. Available from: http://www.scielo.br/pdf/tce/v23n2/pt_0104-0707-tce-23-02-00270.pdf.
7. Leal MC, Gama SGN, editors. Nascer no Brasil: inquérito nacional sobre parto e nascimento. Rio de Janeiro: Fiocruz; 2012.
8. Strapasson MR, Nedel MNB. A institucionalização da violência contra a mulher no processo de nascimento: revisão integrativa. *Rev Enferm UFPE On Line* [serial on the internet]. 2013 Nov [cited 2015 June 3];7(Spec):6663-70. Available from: <http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/4086/pdf/4036>.

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9. Organização Mundial da Saúde. Maternidade segura. Assistência ao parto normal: um guia prático. Genebra: WHO; 1996.
10. Silva MG, Marcelino MC, Rodrigues LSP, Toro RC, Shimo AKK. Violência obstétrica na visão de enfermeiras obstetras. Rev RENE [serial on the internet]. 2014 July-Aug [cited 2015 June 10];15(4):720-8. Available from: <http://www.revistarene.ufc.br/revista/index.php/revista/article/view/1514>.
11. São Paulo (Estado). Violência obstétrica, você sabe o que é? [document on the internet]. 2013 Nov [cited 2015 June 6]. Available from: <http://www.defensoria.sp.gov.br/dpesp/repositorio/41/violencia%20obstetrica.pdf>.
12. Leal MC, Pereira APE, Domingues RMSM, Theme Filha MM, Dias MAB, Pereira MN, et al. Obstetric interventions during labor and childbirth in Brazilian low-risk women. Cad Saúde Pública [serial on the internet]. 2014 [cited 2015 June 7];30(Suppl 1):S1-S31. Available from: <http://www.scielo.br/pdf/csp/v30s1/0102-311X-csp-30-s1-0017.pdf>.
13. Rocha ES, Sousa K, Paula NI, Veronesi CL, Borges Júnior OS, Oliveira MR, et al. Relato de episiotomia como violência obstétrica. Enciclopédia Biosfera [serial on the internet]. 2014 [cited 2015 June 11];10(19):481-7. Available from: www.conhecer.org.br/enciclop/seminario/relato.pdf.
14. Oddy WH. Aleitamento materno na primeira hora de vida protege contra a mortalidade neonatal. J Pediatr [serial on the internet]. 2013 [cited 2015 June 8];89(2):109-11. Available from: <http://www.scielo.br/pdf/jped/v89n2/v89n2a01.pdf>.
15. Pedrosa CM, Spink MJP. A violência contra mulher no cotidiano dos serviços de saúde: desafios para a formação médica. Saúde Soc [serial on the internet]. 2011 [cited 2012 June 10];20(1):124-35. Available from: <http://www.scielo.br/pdf/sausoc/v20n1/15.pdf>.
16. Fujita JALM, Shimo AKK. Parto humanizado: experiências no Sistema Único de Saúde. REME Rev Min Enferm [serial on the internet]. 2014 [cited 2015 June 10];18(4):1006-10. Available from: <http://www.reme.org.br/artigo/detalhes/979>.
17. Belli L. La violencia obstétrica: otra forma de violación a los derechos humanos. Rev Latinoam Bioét [serial on the internet]. 2013 [cited 2015 June 10];1(7):25-34. Available from: [http://www.unesco.org.uy/shs/red-](http://www.unesco.org.uy/shs/red-bioetica/fileadmin/shs/redbioetica/Revista_7/Art2-BelliR7.pdf)

[bioetica/fileadmin/shs/redbioetica/Revista_7/Art2-BelliR7.pdf](http://www.unesco.org.uy/shs/red-bioetica/fileadmin/shs/redbioetica/Revista_7/Art2-BelliR7.pdf).

18. Sánchez RW. Actitud del ginecólogo ante las disfunciones sexuales femeninas. Rev Obstet Ginecol Venezuela [serial on the internet]. 2012 [cited 2015 June 9];72(1):1-3. Available from: <http://www.scielo.org.ve/pdf/og/v72n1/art01.pdf>.

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