



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ORIGINAL ARTICLE

INSTITUTIONAL OBSTETRIC VIOLENCE IN BIRTH: PERCEPTION OF HEALTH PROFESSIONALS

VIOLÊNCIA OBSTÉTRICA INSTITUCIONAL NO PARTO: PERCEPÇÃO DE PROFISSIONAIS DA SAÚDE

VIOLENCIA OBSTÉTRICA INSTITUCIONAL EN EL PARTO: PERCEPCIÓN DE PROFESIONALES DE LA SALUD

Ferdinand José da Costa Cardoso¹, Ana Carla Marques da Costa², Mayron Moraes Almeida³, Thiago Sampaio dos Santos⁴, Francisco Braz Milanez Oliveira⁵

ABSTRACT

Objective: to evaluate the knowledge and practices about obstetric violence in the perception of health professionals. **Method:** this is a descriptive, exploratory study with a qualitative approach, conducted through an interview with 20 health professionals. Data analysis was performed using the Content Analysis technique. **Results:** only 40% of health professionals had or still had contact with obstetric violence, and only 15% reported having committed obstetric violence, demonstrating that obstetric violence is still unknown by health professionals and several reasons for the existence of this problem as bad structuring of health institutions, excessive workload and lack of communication between the professional and the patient. **Conclusion:** most of the professionals were unfamiliar with obstetric violence, through the analysis of the discourses. It is suggested that the solution of the problem of obstetric violence is in the humanization of care. **Descriptors:** Violence; Obstetric, Delivery; Health Personnel; Humanized Birth.

RESUMO

Objetivo: avaliar os saberes e práticas sobre violência obstétrica na percepção dos profissionais da saúde. **Método:** estudo descritivo, exploratório, de abordagem qualitativa, realizado por meio de entrevista com 20 profissionais da saúde. A análise dos dados ocorreu por meio da técnica de Análise de Conteúdo. **Resultados:** apenas 40% dos profissionais da saúde já tiveram ou ainda têm contato com tema violência obstétrica e apenas 15% relataram ter cometido o ato da violência obstétrica, demonstrando que o tema violência obstétrica ainda é desconhecido pelos profissionais da saúde e vários são os motivos para a existência desse problema, como má estruturação das instituições de saúde, carga horária excessiva e falta de comunicação entre o profissional e cliente. **Conclusão:** a grande maioria dos profissionais se mostrou desconhecadora do tema violência obstétrica. Por meio da análise dos discursos, sugere-se que a solução do problema da violência obstétrica está na humanização da assistência. **Descritores:** Violência; Parto Obstétrico; Pessoal de Saúde; Parto Humanizado.

RESUMEN

Objetivo: evaluar los saberes y prácticas sobre violencia obstétrica en la percepción de los profesionales de la salud. **Método:** estudio descriptivo, exploratorio, de enfoque cualitativo, realizado por medio de entrevista con 20 profesionales de la salud. El análisis de los datos fue por medio de la técnica de Análisis de Contenido. **Resultados:** apenas 40% de los profesionales de la salud ya tuvieron o aún tienen contacto con tema violencia obstétrica y apenas 15% relataron haber cometido el acto de la violencia obstétrica, demostrando que el tema violencia obstétrica todavía es desconocido por los profesionales de la salud y varios son los motivos para la existencia de ese problema como mala estructuración de las instituciones de salud, carga horaria excesivas y falta de comunicación entre el profesional y el cliente. **Conclusión:** la grande mayoría de los profesionales se mostraron desconocedores del tema violencia obstétrica, por medio del análisis de los discursos se sugiere que la solución del problema de la violencia obstétrica está en la humanización de la asistencia. **Descriptores:** Violencia; Parto Obstétrico; Personal de Salud. Parto Humanizado.

^{1,3,4}Nurses (graduated), Science and Technology School of Maranhão/FACEMA. Caxias (MA). Brazil. E-mails: nancardosoangel@hotmail.com; mayronmoraes@outlook.com; th_sampa@hotmail.com; ²Nurse, Master's degree Professor in Genetic and Applied Toxicology, Nursing Course, Science and Technology School of Maranhão/ FACEMA. Caxias (MA), Brazil. E-mail: carlama271@gmail.com; ⁵Nurse, Master's degree Professor in Nursing, Nursing Course, Science and Technology School of Maranhão/FACEMA. Caxias (MA), Brazil. E-mail: Braz_cm@hotmail.com

INTRODUCTION

Childbirth is seen and treated only in its mechanical form, in which health professionals leave the parturient in the background at the time of childbirth so it becomes just one more component of that act. Linked to this context, the parturient began to suffer some damages, that at the present time is denominated of obstetric violence. Violence can be defined as imposing a significant degree of pain and suffering that can be avoided, specifically obstetric violence against women encompasses physical, sexual and/or psychological violence.¹

Obstetric violence is understood as any action promoted by the health professionals regarding the body and the reproductive processes of the woman, being characterized by a dehumanized assistance, abuse of interventionist actions, medicalization and reversion of the process from natural to pathological.²

In the world, women suffer abuse, disrespect, and maltreatment during childbirth in health institutions. Such treatment not only violates the rights of women to respectful care, but also it threatens the right to life, health, physical integrity and not-discrimination.³

The process of parturition ceases to be a phenomenon of individual and physiological essence and it happens to be a moment of experiences, often negative experiences, losing the characteristics of female individuality and naturalness, and health workers view delivery as a pathological event and conducive to interventions, making this moment a cold and suffering experience in which the woman is considered as an object.⁴

Thus, this study aims to evaluate the knowledge and practices about obstetric violence in the perception of health professionals. Secondly, it aims to investigate the possible types of obstetric violence practiced by health professionals, to evaluate the perception and perspective on the subject with health professionals, to investigate the factors related to obstetric violence and describe the professionals interviewed about obstetric violence.

METHOD

This is a descriptive and exploratory study with a qualitative approach carried out in a reference maternity hospital in the city of Caxias, located in the eastern state of Maranhão, Northeast Brazil.

The sampling was of the non-probabilistic type, for convenience, composed of 20 health

professionals who accepted to participate in the research and who attended the pregnant women from the beginning of labor to their exit to the postpartum recovery; professionals such as doctors, nurses, technicians and nursing assistants.

The maternity assists 43 municipalities in the region, performing an average of 350 births per month, among normal and cesarean deliveries. The care provided at the institution consists mainly of high-risk prenatal, normal and cesarean deliveries, laboratory tests, ultrasonography, neonatal ICU, and immunization. Regarding the specialties in health, the doctors and obstetrician nurses, pediatricians, neonatal interventionists and technical areas are highlighted.

The term Professional (P) followed by a numerical number was used to maintain the privacy and anonymity of the research participants. Thus, the subjects of the research will be called P01, P02, P03 and etc., for the identification of the speeches within the text.

The inclusion criteria for the present study were being a health professional working in the maternity ward; providing assistance to the parturient and women who have recently given birth; being in good physical and psychological condition and accept to participate in the research. The exclusion criteria were the health professionals who did not provide direct assistance to parturients and who did not work in the maternity ward. The study had risks to professionals regarding the embarrassment to answer some of the questions in the questionnaire, but it should be made clear that at no time was there any type of judgment to professionals.

The data collection took place from August to October 2015, by trained researchers, through a questionnaire containing open and closed questions. The collection took place through periodic visits to maternity where the researcher explained the research objectives and then gave a questionnaire to the professional who accepted to participate in the research. The researcher was present while the professionals answered the questionnaire in case there was any doubt regarding the questionnaire. It is worth emphasizing that the researcher had no influence whatsoever on any response of the professionals who participated in the research.

The technique of Content Analysis was used for the analysis of the data, which is characterized by a set of communication analysis techniques aiming to obtain by

systematic procedures and objectives of description of content, message, indicators, exchanging the knowledge inference in the conditions of production, reception of this message.⁵

Through the analysis and reading of the professionals' discourses, three categories or classes of analyses were formed: 1) The perception and perspective of health professionals about obstetric violence and the types of violence practiced by them; 2) The knowledge of professionals about obstetric violence and 3) Solution for obstetric violence point of view of the health professionals.

Being a research with human beings, the research project was submitted for evaluation by a Research Ethics Committee, approved under the number of CAEE: 49735915.5.0000.5685 and approval opinion

number 1,254,968, as recommended in Resolution 466/2012 of the CNS/MS.

RESULTS AND DISCUSSION

Twenty health professionals participated in the study, two physicians, four nurses and 14 nursing technicians. The time of profession of these professionals ranged from 1 to 30 years, with an average of 12.1 years.

It was found that MOST of the professionals of superior level had some specialization in related areas. All the nurses in the study were able to perform low-risk deliveries without the presence of the physician. Similar results were found in another study with 18 health professionals in the city of São Paulo/SP, where the professionals were recognized as having good training and quality in care. All nurses were trained in obstetrics.⁶

Table 1. Demonstration of the professional profile according to the function, length of service, specialization, and affinity with the area. Caxias (MA), 2015.

Variables		n	%
Function	Doctor	2	10
	Nurse	4	20
	Nursing Technician	14	70
Total		20	100
Service time	< 5 years	6	30
	6 to 10 years	5	25
	11 to 20 years	4	20
	21 to 30 years	5	25
Total		20	100
With Specialization	Yes	7	35
	No	13	65
Total		20	100
Like to work in obstetrics	Yes	17	85
	No	3	15
Total		20	100

◆ The perception and perspective of health professionals about obstetric violence and the types of violence practiced by them.

It was observed that most participants (70%) considered that they did not commit or never committed obstetric violence, only 15% of professionals reported having practiced or who still practice some type of obstetric violence, such as observing the following professional report:

Yes, I already did it. In our health system, we sometimes have to intervene precipitately because of the fear of complications, indicating cesareans, sometimes unnecessary, another complication is the cultural level of some pregnant women who grossly attack the health professional for not accepting the conduct. (PF02)

By this speech, it is noticed that the professional even admits to having committed obstetric violence. However, the professional suggests that the fault of such problem is due

to the health system and/or the culture of the pregnant/parturient.

Aggressive obstetric care that violates the basic rights of women is added to the model of childbirth in force in our country, which is fueled by failures in a health system that does not seek to carry out due health and the precarious training of some professionals.⁷

The attitudes and behaviors of patients and professionals are subject to being misinterpreted by both parties, so there is a truncated communication of reinterpretation of speech and feelings that can cause the patient to collaborate little with the team precisely because they do not understand what expect from her.⁸

Regarding the perception and individual perspective of the professionals about themselves, 70% judged that they did not commit obstetric violence, but when questioned about the perspective and the perception they had about the work colleague, 80% of the interviewees reported having already witnessed colleagues

committing some type of obstetric violence, as evidenced by the following statements:

Yes, I already witness all kinds of violence, I believe that many of them do it by simply arrogance and ignorance of the professional. (P12)

Yes, by a medical colleague, I witnessed it, it was very unfair for the act of bad words and even poor care of not giving a satisfactory explanation to the patient. (P10)

Yes, I already witnessed it, practiced by other colleagues and I found it inhumane. (P8)

Yes, I have already witnessed it, but I was isolated because I did not share the same conduct. (P02)

Yes, I have seen colleagues practicing violence with words, but he is guided of not acting in such a way. (P01)

The professionals have the perception that co-workers commit obstetric violence. For those, the other is the one who performs the act of violence and defines this act as inhuman, they think what the other does wrong, but do not interfere with the conduct. Therefore, it can be affirmed that obstetric violence is present in the daily life of these professionals. However, they do not have the perception that they commit violence with the parturients, but rather this is a common practice of another professional.

It is necessary that changes take place first in the care model of obstetrics and in the curriculum grade during the training of health professionals to promote the appropriate changes of the professionals.⁷

Regarding the types of violence practiced and existing in the maternity ward, about 70% of the interviewees reported that there was the practice of obstetric violence, and they said:

Yes, within the sector where I work verbal violence, cesareans without obstetric indication and medicalization of labor. (P02)

Yes, within the sector where I work, violence as unnecessary interventions; use of medications and staff treating poorly during childbirth. (P03)

Yes, in the sector where I work when necessary I refer to episiotomy, sometimes there are perineal lacerations, in my sector, it is no longer different because it is a place of surgical procedures where only cesareans are performed. (P04)

Yes, it exists in the institution where I work, sometimes it exists because the patient does not understand that it is necessary at times the professional treats the parturient with violence. (P06).

Thus, the types of obstetric violence commonly practiced in maternity are verbal

violence, unnecessary medication administration, and episiotomy, expressed through dehumanized attention, abuse of interventionist actions, medicalization and the pathological transformation of parturition physiological processes.²

Obstetric violence occurs before, during and after childbirth and occurs when the woman's body and reproductive processes are appropriated by health professionals, through dehumanized treatment, abuse of medicalization and pathologization of natural processes, resulting in the loss of autonomy and competence to decide freely about her body and sexuality, generating a negative impact on the quality of life of women. The manifestations of violence against pregnant women/parturients are produced mainly by the health professionals who accompany them.⁹

In the entire process of obstetric violence against women, the term institutional obstetric violence is defined as the disqualification of practical knowledge, life experience, scientific knowledge, and physical violence; Detriment of patients' needs and rights; Prohibition of accompanying person or visits with strict or restricted hours; Criticism or aggression to those who cry out or express pain and despair.¹⁰

A frightening and at the same time revealing fact in the context of humanized practice was observed in the speech of a professional who states:

[...] The patient does not understand that it is necessary to treat her with violence. (P14)

Although this quotation has not been explained or justified by the deponent, we can judge this idea or conduct of the professional through the conception of professionals in accelerating the labor of the woman to stop her pain, resorting to the administration of medication and physical maneuvers inducing the childbirth.

The use of violence in the care of women reveals the weakening of the bases of power and medical authority in relation to the consensus generated based on the communication and action of free subjects, as well as the difficulty in establishing a free communication with the woman, as a subject in fragility and in need of care.⁶ There is a need for changes in the teaching of obstetrics and updating of professionals who work in the novice area in the retraining and updating of the professional.⁹

◆ Knowledge of health professionals about obstetric violence

Health professionals working in the care of women during childbirth have little contact with obstetric violence. Table 2 shows the contact of health professionals with the topic

Table 2. Demonstration of the contact of the professionals with the subject obstetric violence. Caxias (MA), 2015.

Variables	n	%
Have ever heard about	8	40
Have read about the topic	4	20
Never heard about	6	30
Just listened to but had no interest	2	10
Total	20	100

The concern with the data found is relevant, since the lack of contact with the subject obstetric violence by the professionals evidences the detachment of the premises of the humanization since both thematics have a strong relationships. Although many professionals affirm that they did not have contact with the subject, most of them knew how to define obstetric violence:

Obstetric violence is every word or gesture that assaults the parturient. (P01)

Obstetric violence is when you submit a patient to an examination or procedure against their will or cause some embarrassment without clarifying the need for it. (P02)

It is any act against pre-delivery and postpartum women with unhumanized attitudes in care. (P04)

It is focused on the treatment of the patient assisted by the multi-professional team, from admission to discharge, according to WHO is related to every procedure with the patient from the verbal words when considered gross and the patient should be clarified of all the procedures performed. If not, this is violence and also every procedure that is performed without her consent. (P08)

It is when the professional uses the "power" that is assigned to him as a professional to hurt, assault, and humiliate a patient with words, psychological pressure or use unnecessary procedures with the patient without their proper consent. (P12)

As expected, professionals among those who have heard or read something about obstetric violence refer to having some knowledge and mastery of the subject. Something different from the answers of those who have never heard of the subject and of those who only heard some comment on the subject:

I think obstetric violence is for the doctor to treat a patient with rude words and in an unpleasant way so that she is not satisfied. (P10)

of obstetric violence, whether by refresher courses, scientific articles books or by the media, the professionals who only heard (40%) stand out, those who never had contact with the subject (30%) and those who only read about the subject (20%).

I do not know what obstetric violence is. (P11)

For me, from the moment a professional or anyone treats the parturient wrong. (P15)

Obstetric violence for me is something of verbal aggression, it is something that the patient does not want to do or do something she does not want. (P06)

Through the analysis of the professionals' speeches, it can be seen that they do not demonstrate a strong knowledge or knowledge about the subject, but they can conceptualize obstetric violence in a superficial way, albeit poorly. This fact leads to a questioning: Do the health professionals describe what obstetric violence is (albeit superficially)? Why does it exist in institutions where there is care for pregnant women in labor?

In the national study with 18 professionals, it was evidenced that institutional violence is admitted as a common practice by most interviewees, although the definition and naming of what would be institutional violence in the view of these professionals has unclear limits.⁶

The factors related to obstetric violence are the overload of services, the structural conditions of the environment and the precariousness of human and material resources; Difficulties in the relationship between professionals and patients, and vice versa. For the authors, the lack of effective communication between patients and professionals results in a misunderstanding of the vision of one with the other that ends up generating obstetric violence.¹¹

The overload of demands, the structural conditions and the precariousness of material and human resources are identified as difficulties faced daily, having as a consequence of the lack of anesthesiologists on duty to carry out labor analgesics until the prohibition of male escorts in the prep room due to lack of physical space.¹²

However, the precarious assistance of health professionals in child labor is

characterized by limitations that go beyond financial factors and infrastructure. It involves the availability of the health professional, the degree of autonomy, the difficulty of the professionals to accept changes, as well as their development in empathy, acceptance, and care. But for him, the lack of these professionals of contact with the subject which leads to the depersonalization of the assistance offered is what stands out most.¹³

♦ Solution for Obstetric Violence in the point of view of health Professionals

Regarding the possible solutions, from the point of view of the professionals, to the question of obstetric violence only 08 professionals answered effectively the question of the questionnaire, where they stand out:

Childbirth is the last stage of pregnancy, lacking prenatal orientation and humanization. Example: birth attendant has to accompany the pregnant during prenatal and receive guidance, the pregnant has to see lectures on how the childbirth is its advantages and disadvantages. And training of professionals. (P02)

Educate, that is, empower and show employees the meaning of obstetric violence. (P03)

This is a problem that I think will never cease to exist because the human being is very complicated and these procedures, however, they want to avoid them soon, another one will appear. It can be softened I believe, but never cease to exist. This is my opinion, however much one wants to avoid is in vain. (P04)

Training professionals and improving care in basic care. (P09)

There should be more training for these professionals so there are updates as well as good practices, if the professional does not fit, there must be more rigidity of the administration. (P12)

Thus, for interviewees is the qualification of health professionals as the preponderant and passive factor as a tool for the change of care. However, there are other exits besides qualification such as quality care in basic care, where it shows that this issue of obstetric violence begins from humanization in prenatal care within the primary care where the companion should have the responsibility to be present in the consultations prenatal.

The response to obstetric violence is to humanize the care provided to women in the parturients. However, it implies not only humanizing health professionals but humanizing people, including the posture before the life and before how they interact

with the other. Therefore, humanization does not cost billions and billions, neither for the government nor for itself the value of humanization depends only on the size of the will of each being.¹⁴

It is necessary to recognize their individuality to humanize women's care, realizing the needs of each woman and also the abilities to deal with the phenomenon of birth, in a way that the cultural context of each woman, her historical and anthropological context can be recognized. They determine the forms of knowledge and action of each woman facing the health-disease process.¹⁵

CONCLUSION

In this study, it was evidenced that obstetric violence goes far beyond the poor quality treatment of women in labor. Obstetric violence is a reality present in our society and not characterized as a problem of social class. It is a problem that is in the whole social sphere. It is noticed that the professional often imposes his hierarchical dominion on the patient, and this one by not understanding the subject ends up suffering such violence.

It was observed that most of the study participants did not report the practice of obstetric violence. It has as factors related to the practice and existence of obstetric violence with poor working conditions of professionals and the precariousness of human resources.

A likely and more feasible solution to such a problem may be the practice of humanized assistance. However, humanization depends on updating the professionals and the humanized praxis of each one.

There is a need for health professionals to maintain a horizontal relationship with the parturient, encouraging her and allowing autonomy at the time of delivery to act as the protagonist of her pregnancy and delivery and making decisions that concern their care.¹⁶

Obstetric violence is present during labor and even superficially, health professionals acknowledge their existence, by treating the patient roughly or by doing some undue procedure on the patient. There are no major projects to solve such a problem these days. There are policies and protocols that advocate humanized assistance, but it is noted that most professionals do not care about promoting humanized care and many of the institutions are not yet prepared for such a change.

REFERENCES

1. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, Javadi D. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. *PLoS Med* [Internet]. 2015 [cited 2016 Aug 14];12(6):1-30. Available from: <http://journals.plos.org/plosmedicine/article/asset?id=10.1371%2Fjournal.pmed.1001847.PDF>
2. Diniz SG, Salgado HO, Andrezzo HFA, Carvalho PGC de, Carvalho PCA, Aguiar CA, et al. Rev bras crescimento desenvolv hum [Internet]. 2015 [cited 2016 Aug 14];25(3):377-84. Available from: http://pepsic.bvsalud.org/pdf/rbcdh/v25n3/p_t_19.pdf. <https://dx.doi.org/10.7322/jhgd.106080>.
3. World Health Organization. The prevention and elimination of disrespect and abuse during facilitybased childbirth: WHO statement. Geneva: World Health Organization [Internet]. 2014 [cited 2016 Aug 14]. Available from: http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf.
4. Santos LM, Pereira SSC. Vivências de mulheres sobre a assistência recebida no processo parturitivo. *Physis*. [Internet]. 2012 [cited 2016 Aug 14];22(1):77-97. Available from: <http://www.scielo.br/pdf/physis/v22n1/v22n1a05.pdf>.
5. Bardin, L. Análise de conteúdo. 70th ed. Lisboa; 2008.
6. Aguiar JM de, D'Oliveira AFPL, Schraiber LB. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais da saúde. *Cad Saúde Pública* [Internet]. 2013 [cited 2016 Aug 14];29(11):2287-96. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2013001100015&lng=en.
7. Moiety FMS, Azzam AZ. Fundal pressure during the second stage of labor in a tertiary obstetric center: a prospective analysis. *J Obstet Gynaecol Res*. [Internet]. 2014 [cited 2016 Aug 14];40(4):946-53. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/24428496>.
8. Priddis H, Dahlen H, Schmied V. What are the facilitators, inhibitors, and implications of birth positioning? A review of the literature. *Women Birth*. [Internet]. 2012[cited 2016 Aug 14];25(3):100-6. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/21664208>.
9. Muniz BMV, Barbosa RM. Problematizar la atención del parto: es cuidado o violencia? *Memorias Convención Internacional de Salud Pública. Cuba Salud*. [Internet] 2012 [cited 2016 Aug 14];3(7):321-31. Available from: <http://www.convencionsalud2012.sld.cu/index.php/convencionsalud/2012/paper/view/744/321>.
10. Ministério da Saúde (Brasil). Violência Intrafamiliar: Orientações para a Prática em Serviço. *Cadernos de Atenção Básica*. [Internet]. 2th ed. Brasília - DF: 2003. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/cd05_19.pdf.
11. Aguiar JM de, D'Oliveira PLAF. Violência institucional em maternidades públicas sob a ótica das usuárias. *Interface: Comunicação Saúde Educação*. [Internet]. 2011 [cited 2016 Aug 14];15(36):79-91. Available from: <http://colpos.redalyc.org/articulo.oa?id=180119115004>.
12. Pereira JC, Silva JCO, Borges NA, Ribeiro MMG, Auarek LJ, Souza JHK De. Violência obstétrica: ofensa à dignidade humana. *Braz J Surg Clin Res*. [Internet] 2016 [cited 2016 Aug 14];15(1):103-8. Available from: http://www.repositorio.ufop.br/bitstream/123456789/6646/1/ARTIGO_Viol%C3%AanciaObst%C3%A9tricaOfensa.pdf.
13. Souza JP, Castro PC. Sobre o parto e o nascer: a importância da prevenção quaternária. *Cad Saude Publica*. [Internet]. 2014 [cited 2016 Aug 14];30(Supl):11-13. Available from: <http://dx.doi.org/10.1590/0102-311XPE02S114>.
14. Tesser CD, Knobel R, Andrezzo HF de A, Diniz SG. Violência obstétrica e prevenção quaternária: o que é e o que fazer. *Ver Bras Med Família Comunidade*. [Internet]. 2015 [cited 2016 Aug 14];10(35):1-12. Available from: [http://dx.doi.org/10.5712/rbmfc10\(35\)1013](http://dx.doi.org/10.5712/rbmfc10(35)1013).
15. Andrade BP, Aggio CM. Violência obstétrica: a dor que cala. *Anais do III Simpósio Gênero e Políticas Públicas*. [Internet]. 2014 May [cited 2016 Aug 14];1-7. Available from: http://www.uel.br/eventos/gpp/pages/arquivos/GT3_Briena%20Padilha%20Andrade.pdf.
16. Ministério da Saúde (Brasil). Além da sobrevivência: Práticas integradas de atenção ao parto, benéficas para a nutrição e a saúde de mães e crianças. Brasília; 2011. [cited 2016 Aug 14]. Available from: http://www.sbp.com.br/pdfs/Alem_sobrevivencia_Praticas_integradas_atencao_parto.pdf

Cardoso FJC, Costa ACM da, Almeida MM de et al.

Institutional obstetric violence in birth...

Submission: 2016/09/27
Accepted: 2017/07/16
Publishing: 2017/09/01

Corresponding Address

Ana Carla Marques Costa
Coordenação de Graduação em Enfermagem
Faculdade de Ciências e Tecnologia do
Maranhão - FACEMA
Rua Aarão Réis, 1000
Bairro Centro
CEP: 65606-020 – Caxias (MA), Brazil