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ORIGINAL ARTICLE

WOMEN'S PERCEPTION ON OBSTETRIC VIOLENCE PERCEPÇÃO DAS MULHERES SOBRE VIOLÊNCIA OBSTÉTRICA PERCEPCIÓN DE MUJERES SOBRE VIOLENCIA OBSTÉTRICA

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ABSTRACT

Objective: to characterize obstetric violence experienced by women during the parturition process. **Method:** it is a descriptive, exploratory, qualitative study of 20 women from a reference public maternity hospital in Teresina (PI), Brazil. The data were produced by recorded interviews, transcribed in their entirety and analyzed by the Focal Group Technique. The data were collected in March 2016. **Results:** the socio-demographic profile of the women was analyzed. After analyzing the interviews and considering the object of study, two categories emerged: << Negligence in care >> and << Verbal aggression >>. **Conclusion:** violence was characterized in a variety of ways, ranging from neglect of care, denial of rights and clarifying diagnostic information, to verbal assaults at the time of childbirth. **Descriptors:** Violence; Obstetric; Women's Health.

RESUMO

Objetivo: caracterizar a violência obstétrica vivenciada pelas mulheres durante o processo parturitivo. **Método:** estudo descritivo, exploratório, de abordagem qualitativa, realizado com 20 mulheres de uma maternidade pública de referência em Teresina (PI), Brasil. Os dados foram produzidos por entrevistas gravadas, transcritos na íntegra e analisados pela Técnica do Grupo Focal. A coleta dos dados foi realizada no mês de março de 2016. **Resultados:** analisou-se o perfil sociodemográfico das mulheres. Após análise das entrevistas e considerando o objeto de estudo, emergiram duas categorias << Negligência na assistência >> e << Agressão verbal >>. **Conclusão:** a violência foi caracterizada de diversas formas, envolvendo desde a negligência na assistência, a negativa de direitos e de informações esclarecedoras de diagnóstico, até as agressões verbais na hora do parto. **Descritores:** Violência; Obstetrícia; Saúde da Mulher.

RESUMEN

Objetivo: caracterizar la violencia obstétrica vivenciada por las mujeres durante el proceso parturitivo. **Método:** estudio descriptivo, exploratorio, de enfoque cualitativo, realizado con 20 mujeres de una maternidad pública de referencia en Teresina (PI), Brasil. Los datos fueron producidos por entrevistas grabadas, transcritas e su íntegra y analizadas por la Técnica de Grupo Focal. La recolección de los datos fue realizada en el mes de marzo de 2016. **Resultados:** fueron analizados el perfil sócio-demográficos de las mujeres, después del análisis de las entrevistas y considerando el objeto de estudio, surgieron dos categorías << Negligencia en la asistencia >> y << Agresión verbal >>. **Conclusión:** la violencia fue caracterizada en diversas formas, envolviendo desde la negligencia en la asistencia, la negativa de derechos y de informaciones esclarecedoras de diagnóstico, hasta agresiones verbales en la hora del parto. **Palabras clave:** La Violencia; Obstétrica; Salud de la Mujer.

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INTRODUCTION

Obstetric violence is characterized by the appropriation of the body and the reproductive processes of women by health professionals, by dehumanized treatment, medication abuse and pathologization of natural processes, causing loss of autonomy and ability to freely decide on their bodies and sexuality, Negatively affecting the quality of life of women.¹

Childbirth is a social event that integrates the list of the most significant human experiences for those involved. Unlike other events that require hospital care, childbirth is a normal physiological process that requires care and shelter. Despite this, according to the current literature, this moment is often permeated by institutional violence, committed precisely by those who should be their main caregivers.² In this perspective, childbirth care in Brazil is often seen as a form of violence against women, in which they are depersonalized, dehumanized and subjected to a series of interventions, often unnecessary, such as the usual practice of episiotomy. However, the preconceptions still present in the training of health professionals and the organization of hospitals mean that the frequent violations of human rights and reproductive rights won by women are incorporated and become part of the "normal routine" of obstetric care.³

Violence in parturition care is a serious problem for women's health. It is evident that 25% of Brazilian women have already suffered some violence during their labor and delivery. This violence is a result of the very precariousness of the health system, which also considerably restricts access to the services offered. This scenario causes many women in labor to go through a real pilgrimage in search of a vacancy in the public health service network, with a serious risk to their lives and their concept due to lack of care promptly.⁴

Enabling women to have a companion of their choice in labor, delivery and postpartum is considered a beneficial practice that should be encouraged and supported by scientific evidence. Women who receive continuous support during labor compared to those who do not have a supportive provider are more likely not to have a cesarean section and to have a normal delivery without the use of analgesia; reduced labor time; less dissatisfaction with the experience of the birth process.⁵

The devaluation of natural childbirth and the increasing practice of unnecessary surgical

interventions show how much the female population is lacking in information and health education. Ignorance and disrespect, sexual and reproductive rights, as well as the human rights of women, imposing derogatory norms and moral values carried out by some health professionals. Such norms and values are also pointed out as important factors in the formation of the complex network of relationships involving violence attitudes to women.^{4,6}

In this way, it is evident the need to reflect that it is necessary to modify the access to the basic reproductive right, implementing strategies to increase safety, a humanized care, increasing the satisfaction of users, in maternity wards and hospitals, with the intention that the services in these places can be a rewarding experience for the parturients. From this perspective, this study aims to:

- Characterize the obstetric violence experienced by women during the parturition process.

METHOD

This is a descriptive, exploratory study of a qualitative approach carried out in a public maternity hospital, a reference in the high complexity care to women's health in the State of Piauí (PI), Brazil.

The institution is a large public hospital responsible for 63% of births in the city of Teresina. The number of hospitalizations per month has an average of 1,200, of which 900 are childbirths, with medium and high complexity assistance to the woman and the child, as well as actions to promote and prevent health. It works as a school hospital for undergraduate and postgraduate courses in health areas.⁷

The research participants were women who sought care in the referred maternity in the parturitive process. As an inclusion criterion, women should have had a care in that institution and sign the Informed Consent Form (TCLE). Women who remained in the preterm room, the infirmary of pregnant women, and women who presented any physiological and psychological alterations that made their participation unfeasible were excluded.

Data collection was done through the technique of the focal group (FG) and complementary interviews. Data collection was performed in March 2016, with the help of a tape recorder with authorization from the institution and acceptance of the deponents. The interviewees were identified by flowers. FGs are discussion groups that dialogue on a

topic, as they receive appropriate stimuli for discussion. This technique is distinguished by its characteristics, mainly by the process of group interaction, which is a result of the data search.

The technique facilitates the formation of new and original ideas. It generates possibilities contextualized by the study group. It opposes the interpretation of beliefs, values, concepts, conflicts, confrontations and points of view, and enables to understand the narrowing about the theme, in everyday life.

The focal group, as a research technique, uses group discussion sessions, centralizing a specific topic to be debated among the participants. The research focused on the Women's Perception of Obstetric Violence, being developed by a group of women who had given birth. The focus group included a meeting with one mediator and 20 women participants. The process was carried out by interview, highlighting as positive points the conduction to critical thinking, the process of desalienation and the possibility of this technique to reveal singular meanings and to which they relate, from the subjects studied. It should be emphasized that the focus group had as its objective the best approach to the theme "Women's Perception of Obstetric Violence," deconstructing and reconstructing concepts and seeking new answers to the concerns that the theme combines.⁸

Regarding the ethical-legal competencies, since it was a question of research involving human beings, the precepts outlined in Resolution N° 466/2012 of the National Health Council were obeyed. This research protocol was approved by the Research Ethics Committee of UNINOVAFAPÍ University Center, under the CAAE: 53911616.4.0000.5210.

RESULTS

The research had 20 women, who sought care at a public maternity hospital in the State of Piauí, which is a reference to the high-complexity care for women. The following data were obtained from the research script used:

The participants' age ranged from 15 to 49 years old. Predominated housewives (12), in a stable union (13), with low income (14) and complete high school (10).

Regarding the obstetric history, the research revealed that seven participants had one child, five had two children, seven had three children and one had four children. Most of them (13) had normal labor.

The data obtained in the research were treated according to the Thematic Content

Analysis Technique. In keeping with the negligence and disrespectful phrases and situations of our results, we are faced with studies that demonstrate that the greatest need for a woman in labor is in the management of emotional control, since the women point out as a determining factor for a labor experience positive the trust in the team that is assisted and emphasize the importance of the care, patience, and calm by the professionals. However, these women are unaware that this humanized attention must be a technical skill inherent in obstetrics.

The set of analyzed data is highlighted by the fact that practically the women interviewed evidenced disinformation about their rights as a parturient. Two categories of women emerged from the reports: Neglect of Care and Verbal Aggression.

The term obstetric violence is relatively new, although women are disrespected when seeking sexual and reproductive health care for a long time. On the other hand, ignorance and disrespect, sexual and reproductive rights, as well as the human rights of women imposing derogatory norms, and moral values carried out by some health professionals. These norms and values are also pointed out as important factors in the formation of the complex network of relationships involving attitudes of violence against women. Most of this maltreatment is related to a gender-discriminatory assistance, intertwined with issues of social class and ethnicity underlying the permanence of an ideology that naturalizes the social and reproductive status of women with their biological destiny.

The set of data analyzed surprised by the fact that practically the women interviewed evidenced disinformation about their rights as parturients. Two categories of women emerged from the reports: Neglect of Care and Verbal Aggression.

◆ Neglect of care

This category showed and grouped situations of negligence in care within the health institution.

[...] I arrived I was assisted, they called the doctor who was drinking coffee, almost did not come there gave the touch put the serum and returned to the coffee room to have coffee. Moreover, there I stayed in the room alone [...] (Lis Flower)

[...] not yet it is not time, no, there I was left alone [...] (Daisy Flower)

[...] I had eclampsia and twice I was close to dying, my luck was that the doctor forgot something and came back in the room when she arrived I was giving eclampsia and they

took me to the delivery room [...]] (Passion Fruit Flower)

All women have the right to receive information about their state of health, and the procedures indicated, in clear language, in a respectful and understandable way. The health professional has a duty to explain the purpose of each intervention or treatment, as well as the risks or possible complications and the alternatives available. Based on this information, the woman has the right to refuse treatments or procedures in her body, which is called the right of informed refusal.

[...] at the time I was born, I went down to call the nurse, I opened the door that it came almost the child is born [...] (Lis Flower)

The parturient is vulnerable in the sense that she is performing a task that should not be hindered by any other question than the very act of giving birth. The moment requires the environment to protect the woman. It is fundamental that the monitoring of labor and delivery is a time of trust and security between professional and client. It is necessary to take care of guidelines to each procedure, valuing the active participation of the parturients and respecting the moment of pain.

[...] I found it very shocking because to me I was so bewildered in the maternity for an hour without understanding how I was crying and so nobody came to help me.

Childbirth is a social event that integrates the list of the most significant human experiences for those involved. Unlike other events that require hospital care, childbirth is a normal physiological process that requires care and shelter. Despite this, according to the current literature, this moment is, several times, permeated by institutional violence, committed precisely by those who should be their main caregivers.

[...] I went into the maternity ward at 10 o'clock on the night of day 09, and I was in pain until 11, 11 and 05 in the morning. There, back and forth my son was born dead because of this, they had to revive him at the time, thank God they revived him. Only they told me that it was negligence that it was for me to have had a cesarean, I was not able to have him normal; he was born very big with 51cm, 3k and 900 very big and they lacquered me. [...] (Orchid Flower)

It is believed that it is the responsibility of the health team to provide clear information about the care provided, it is an essential condition.

◆ **Verbal aggression**

Verbal violence is an aggressive behavior, characterized by harmful words that it intends

to ridicule, humiliate, manipulate and/or threaten. As with physical violence, this type of aggression significantly affects the victim, causing brutal and irreparable psychological damage.

[...] the doctor kept telling me to shut up [...] (Milk Cup Flower)

[...] in fact at the time of delivery, I was even called dumb by the doctor, in the case [...] (Tulip Flower)

What was meant to be a perfect moment, it has become a bad memory in the patient's life. There was a lack of communication and respect from the professional.

DISCUSSION

It is unfortunate that at the time of giving birth, the most expected moment of a woman, the professional acted with a disregard for it. Undergoing the same humiliating condition. Neglect is the lack of care of professionals towards parturients, from the lack of necessary information to deprivation of care.⁹

Childbirth is an event that integrates the reproductive experience of the woman and her partner. Given the scenario in which the doctor's discourse has much more power than that of the woman in the delivery, the anxieties, and opinions of these are not, in most cases, recognized or translated into the dominant discourse.¹⁰

Law N° 11,108, published in the Federal Official Gazette, states that the emotional support of a trusted companion of the parturient - and made to her choice - is important so that the woman can endure the pain and tension. For this reason, it is important that physicians and other health professionals are aware of the importance of the presence of the companion during labor.¹¹

The professional health-patient relationship, usually asymmetric makes women feeling less able to choose and assert their desires, having difficulties in participating in the decision regarding the technical issues raised by health professionals. This fact could be solved or at least mitigated by the practice of humanization in the delivery and delivery care, which encompasses nursing care during the puerperal pregnancy process.⁶

Humanization is concerned with the provision of care that has as priority the quality of care ensuring respect for the patient's rights, individuality and culture, as well as the evaluation of the professional who provides the care, establishing a concrete environment in health institutions, that

regulates the human side of the people involved in the caring process.¹²

The woman and her body have been seen as machines, where the engineer is the medical professional who has all the knowledge about her, neglecting information, emotions, feelings, perceptions and rights of the same in gestating and giving birth, being prevented from having the presence to decide the position that their babies want and to express their emotions and feelings, contrary to the National Humanization Policy and changing the focus of the woman to the procedure, leaving them more vulnerable to violence, silenced by professionals and by the parturient. However, the bitter experience and trauma accompany the woman outside the institution.¹⁴

By being focused on the birth of her child, the victim may not be so upset with obstetric violence at the time of their suffering. Verbal violence refers to rude treatment, threats, shouting, humiliation and verbal abuse.¹⁵

The woman who must endure the pain of childbirth as something she is biologically capable of bearing, and as the price for the supposed pleasure felt in the sexual act that gave birth to that gestation.¹⁶

The language used in the relationship between the health professional and the patient must have the same meaning for both. Otherwise, the communication process will not occur, and if the communication does not occur, the care provided can be profoundly affected. The communication should be considered as interpersonal competence to be acquired by the health professional who, by using it in a therapeutic way, will allow it to assist the patient in all his dimensions.²⁰

CONCLUSION

What is recognized as obstetric violence, it can be observed that such violence was cited in its various forms, from negligence in care, denial of rights such as having to accompany in all parturitive process, negative diagnostic information to verbal assaults. In this sense, it is important to highlight the importance of obstetric violence that can harm civil, human and even criminal rights. Obstetric violence is still little recognized as a violent act because at the same time it occurs, women are experiencing strong emotions, which make them silent, and it is necessary to address the rights of women during pregnancy, childbirth and postpartum.

In the academic context, obstetric violence is a common day-to-day issue, as it has highlighted in aspects that involve human

relationships and the sociocultural context. The present study contributed by giving the professionals a panorama on the subject, enabling the understanding and the discussion of the theme. In this way, it is evident the need to reflect that it is necessary to modify access to the basic reproductive right. Implementing strategies to increase safety, a humanized care, increase the satisfaction of the patients, in the maternity wards and hospitals with the intention that the attendance in these places can be a rewarding experience for the parturients.

It is up to the managers, health professionals and community to claim the implementation of public policies aimed at the adequate care of women, ensuring that this occurs in a more humanized way at that moment, one of which is more vulnerable and devoid of emotional support.

We hope to raise reflections about the humanization of care in parturition and the need for health professionals and academics from the various courses in the health area to live, feel and internalize humanized care and, from this process, become aware of the importance of their role in assisting women.

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