



VIOLENCE IN CHILDBIRTH: INTEGRATIVE REVIEW

VIOLÊNCIA NO PARTO: REVISÃO INTEGRATIVA

VIOLENCIA EN EL PARTO: EXAMEN INTEGRADOR

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ABSTRACT

Objective: to identify the scientific production about violence against women during childbirth. **Method:** integrative review with a view of answering the guiding question: What is the scientific production about violence against women at the time of childbirth? Articles published in Portuguese, English or Spanish, found in full, between 1995 and 2014, with the descriptors "violence and women and childbirth", indexed in the MEDLINE, CINAHL, LILACS and BDENF databases were included. **Results:** the research resulted in 11 studies, ten developed in Brazil, published since the year 2000 and all recognized violence as a problem. **Conclusion:** women experience and report unfavorable and harmful conditions at birth, but do not recognize these factors as violence, since professionals attribute inadequate behaviors to lack of physical structure, unsatisfactory working conditions, and the need to organize and control the service. **Descriptors:** Violence; Women; Parturition.

RESUMO

Objetivo: identificar a produção científica acerca da violência contra a mulher no parto. **Método:** revisão integrativa com vistas a responder a questão norteadora: *Qual a produção científica existente acerca da violência contra a mulher no momento do parto?* Foram incluídos artigos publicados em português, inglês ou espanhol, encontrados na íntegra, entre os anos de 1995 e 2014, com os descritores violência and mulheres and parto, indexados nas bases de dados MEDLINE, CINAHL, LILACS e BDENF. **Resultados:** A pesquisa resultou em 11 estudos, dez desenvolvidos no Brasil, publicados a partir do ano de 2000 e todos reconheceram a violência como um problema. **Conclusão:** as mulheres vivenciam e relatam condições desfavoráveis e prejudiciais ao nascimento, mas não reconhecem esses fatores como violência, já os profissionais atribuem as condutas inadequadas a falta de estrutura física, condições insatisfatórias de trabalho, a necessidade de organizar e controlar o serviço. **Descritores:** Violência; Mulheres; Parto.

RESUMEN

Objetivo: identificar la producción científica sobre la violencia contra la mujer en el parto. **Método:** revisión integradora con el fin de responder a la pregunta: *¿Cuál es la literatura científica existente sobre la violencia contra la mujer en el momento del parto?* Hemos incluido artículos publicados en Portugués, Inglés o español, encontrados en su totalidad, entre los años de 1995 y el 2014, con los descriptores violencia y mujeres y parto, indexados en las bases de datos MEDLINE, CINAHL, LILACS y BDENF. **Resultados:** la investigación resultó en 11 estudios, diez desarrollados en Brasil, publicados desde el año 2000, y todos reconocen la violencia como un problema. **Conclusión:** las mujeres viven y relatan condiciones desfavorables y perjudiciales al nacimiento, pero no reconocen estos factores como la violencia, ya lo profesionale atribuyen las conductas inapropiadas a la falta de estructura física, condiciones insatisfactorias de trabajo, la necesidad de organizar y controlar el servicio. **Descritores:** Violencia; Mujeres; Parto.

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INTRODUCTION

As Women constitute the majority of the population of Brazil and are, without doubt, the main users of the Unified Health System (UHS). However, this proximity has not been enough to solve the problems experienced by them, such as violence, which is now considered a serious public health problem in society.¹

Over the years, many efforts have been spared in order to solve, combat and prevent this aggravation, which is associated with the historical inequalities of power between women and men, involving gender relations and issues such as race, ethnicity, poverty, sexual orientation, age, among others.¹

One of the coping strategies is Law nº 11.340 / 2006, known as the Maria da Penha Law, which was an important step towards curbing domestic and family violence against women, as well as conceptualizing violence in physical, psychological, sexual, patrimonial and moral.²

Violence against women can occur in many places such as home, the streets, work and health institutions. This last type, institutional violence, has gained wide visibility in recent years and has been the subject of studies, mainly, the discussion of this violence at the time of childbirth, which is a physiological process, and should be a moment of joy, care and welcoming.³⁻⁴

While many health professionals work for women's rights, such as reproductive rights, unfortunately in the setting of maternities and hospitals situations of disrespect and humiliation are found. Faced with these facts, most remain silent because of the fear of what could happen if they expressed their opinion regarding what they are feeling and experiencing, such as not receiving care.

Obstetric violence can manifest as neglect in care, discrimination, verbal, physical, sexual, psychological, gender violence. Examples are gross treatment, threats, reprimands, shouting, humiliation, failure to use analgesic medication when indicated, abuse of power, painful touches, prejudice with certain population groups, such as black people.³⁻⁴

To explain this problem, studies point to structural difficulties, such as the precariousness of services, working conditions and assistance models. These are centered on the professional rather than the user, management models are authoritarian, there is a lack of respect for the rights of women and companions, there are workers' prejudices

and the empowerment of labor by those who lead it.^{4,7-9}

To change this panorama experienced in the maternity homes, it is important to develop studies in search of scientific evidence capable of generating changes. Several strategies have been implemented in order to reverse this situation, such as the National Humanization Policy (NHP) focusing on childbirth and birth, the Maternity Qualification Plan (MQP) and the Stork Network.⁹

Faced with this problem, this study aims to: identify the existing scientific production about violence against women in childbirth.

METHOD

Integrative review of the literature organized in six stages: establishment of the research question, search in the literature, categorization of studies, categorization of articles included in the review, interpretation of the results and the presentation of the review.¹⁰⁻¹

The question that guided the present research was: What is the scientific production about violence against women at the time of childbirth?

For the refinement of the research, the following inclusion criteria was used: articles published in English, Portuguese and Spanish. The exclusion criteria were: dissertations, theses, articles that are not available and that did not meet the exclusion criteria.

Articles published in national and international scientific journals dealing with violence against women at the time of delivery, available in Portuguese, English or Spanish, were found in full and published between 1995 and 2014. Publications should be available on-line in the databases: LILACS, BDNF, MEDLINE and CINAHL.

For the location of the publications, the descriptors of the Health Sciences (DeCs) were used, accompanied by the Boolean and: Violence and Women and Childbirth, for being the ones that best fit the objectives. Other descriptors such as Institutional Practice and Childbirth and Violence, were not effective in the searches, being found publications with different themes.

The articles were classified as level of evidence: level 1 - systematic reviews or meta-analysis of relevant clinical trials; level 2 - evidence derived from at least one well-delineated randomized controlled trial; Level 3 - well-delineated clinical trials without randomization; level 4 - well-delineated cohort and case-control studies; level 5 -

systematic review of descriptive and qualitative studies; level 6 - evidence derived from a single descriptive or qualitative study and level 7 - opinion of authorities or report of expert committees.¹²

Data collection took place between October and November 2014 and was subsidized by a validated instrument in 2005.¹³

The search led to the gathering of 95 articles, which underwent an initial analysis with the reading of titles and abstracts, to select research that answered the objective. After the first reading the selected ones were read in full, four studies appeared in more than one database, 80 did not meet the criteria of the work and 11 composed the final sample, according to figure 1.

RESULTS

Databases	Found	Did not meet the inclusion criteria	Repeated	Selected for the study
LILACS	38	30	02	06
BDENF	08	04	02	02
MEDLINE	47	44	0	03
CINAHL	01	01	0	00
Total	95	80	04	11

Figure 1. Distribution of articles by database. Piranguçu (MG), Brazil, 2015.

For the analysis of the articles the variables country, author, year, authors and training, objectives and results were used. Figure 2

refers to the studies found. It was verified that:

Title	Year	Authors and qualifications	Objectives	Results	Level of evidence
A1. Body, power and the act of partying: reflections in the light of gender relations	2000	- Lúcia Helena Rodrigues Costa Nurse at the Federal University of Santa Catarina (UFSC).	Reflect and discuss some points about the issues regarding the female body and the power that permeates the act giving birth.	Gender violence at the time of childbirth can only be minimized through humanization actions.	7
A2. Symbolic power, violence and domination in public health services.	2004	- Wilza Rocha Pereira PhD, professor at the Federal University of Mato Grosso.	To apprehend the subtle faces of the symbolic violence, power and domination present in the actions and health practices of the various professionals directed to women in gestation, childbirth and the puerperium.	I conclude that in the relationships established between patients and medical staff, there are symbolic elements that contribute greatly to the invisibility of this type of violence that is very present in health practices.	6
A3. Indicators of care for the body that procreates: pre-trans and postpartum nursing actions - a contribution to the practice of obstetric nursing	2004	- Nêbia Maria Almeida de Figueirêdo -Maria Antonieta Rubio Tyrrell -Vilma de Carvalho -Joséte Luzia Leite Doctors, professors of the University of Rio de Janeiro.	To identify and discuss nursing actions when caring for women during pre - trans and postpartum care.	Categories: Body care in labor (un)due invasion and veiled violence; the (lack of) care of the body that expels another body, the invasion and violence shown; The (lack of) care of the empty body: "tiredness and solitude" "the violence of abandonment". Violence over the body of a woman in childbirth should be	6

				avoided.	
A4. Hospital delivery - experiences of women from the outskirts of Cuiabá-MT	2006	-Neuma Zamariano Fanaia Teixeira. Master. -Wilza Rocha Pereira Doctor.	To analyze some cultural aspects that crossed the experiences of women when they undergo the normal hospital birth of UHS.	The experiences were related to an institutional culture that revealed a care based on veiled violence and in disrespect to the NHP principles of the Ministry of Health.	6
A5. Consented Violence: women in labor and delivery	2008	-Leila Regina Wolff Nurse. PhD in Nursing Sciences. -Vera Regina Waldow Nurse. PhD in Nursing Education.	Report how care is given in many health institutions and reveal the circumstances that women are subjected to in the process of parturition, which are characterized by actions of non-care and / or dehumanization.	The reports highlighted situations of non-care and / or dehumanization of care for women in labor and delivery, evidenced a special type of gender-based violence in the area of health, consensual violence.	6
A6. Equity and women's health services for contraception, Abortion and childbirth in Brazil	2012	-Simone G. Diniz, Professor at the University of São Paulo, -Ana Flávia Pires Lucas d'Oliveira, Professor at the University of São Paulo -Sonia Lanskyc, Pediatrician, President of the Perinatal Commission, Ministry of Government of the City of Belo Horizonte.	It addresses equity in health and health care in Brazil, examining the disparities between women and men, and women from different social strata, focusing on services for contraception, abortion and pregnancy.	Women's life expectancy is higher than men's, the fertility rate has dropped in recent years, prevalence of contraceptive use has increased in all classes, abortions are mostly illegal. The institutional violence of health professionals is reported by women after abortion and during delivery. To achieve equity, one must offer universal access to technology and move towards safe, effective and transparent assistance.	7
A7. Birth in Cuba: analysis of the experience of medical delivery from an anthropological perspective	2013	- Dailys Dr. C. Garcia Jorda - Lic. Marlen Acosta Álamo - Dr. C. Zoe Bernal Diaz University of Havana. Havana, Cuba.	Understand the representations and practices related to childbirth and describe the experience of women.	All births had numerous medical interventions, men's participation was limited. In the anthropological perspective, the routine use of medical interventions and the institutional norms described are considered manifestations of physical and gender violence.	6
A8. Institutional	2013	-Janaina Marques	To present and	The analysis	6

violence, medical authority and power in maternity hospitals from the point of view of health professionals		de Aguiar -Ana Flávia Pires Lucas d'Oliveira -Lília Blima Schraiber School of Medicine, University of Sao Paulo.	discuss data from a survey conducted with health professionals about institutional violence in public maternity hospitals.	revealed the recognition of these professionals of the existence of discriminatory and disrespectful practices in the daily care of pregnant, parturient and postpartum women, showing the banalization of institutional violence.	
A9. Kind of groggy and with bound hands: the first contact with the newborn according to women who had an unwanted caesarean section	2013	-Heloisa de Oliveira Salgado -Denise Yoshie Niy -Carmen Simone Grilo Diniz University of Sao Paulo.	Describe and analyze the experience and feelings of women who report experiencing an unwanted cesarean on first contact with their newborn children.	Most women report having suffered some type of violence during the care.	6
A10. From institutionalized childbirth to home birth.	2014	-Clara Fróes de Oliveira Sanfelice, -Fernanda de Souza Freitas Abbud, -Livvia Separavich Pregnotatto, -Michelle Gonçalves da Silva, Antonieta Keiko Kakuda Shimo Campinas State University. Campinas.	To describe the experience of a group of obstetrician nurses from the city of Campinas, SP, Brazil, about the process of transition from institutionalized childbirth care to home birth, in the period from 2011 to 2013.	Four thematic categories were found: the hospital experience; living with obstetric violence; back home and the challenges of home care. It was concluded that home delivery has offered greater satisfaction to nurses, with assistance to women and integral NB..	6
A11. Home birth: advancement or regression?	2014	-Clara Fróes de Oliveira Sanfelice Obstetrician nurse, PhD student. -Antonieta Keiko Kakuda Shimo Nurse Obstetrician, PhD, Federal University of Campinas.	To present a brief overview of home delivery care, problematizing the reality of the contemporary Brazilian obstetric scenario.	The scientific literature shows obstetric and neonatal outcomes favorable to home delivery and higher rates of maternal satisfaction. Nowadays there is a movement of women, who have chosen to give birth at home as a reaction to institutional violence, to the fragmentation and depersonalization of hospital care.	7

Figure 2. Distribution of the articles of the integrative review. Piranguçu (MG), Brazil, 2015.

Of the articles found, ten studies were developed in Brazil and only one in another country, Cuba. Among the authors, there was a predominance of nurses, professionals in the areas of obstetrics and pediatrics, being 100% female. Among the articles published by Brazilians only two belonged to international journals, the others were published in the country itself.

The articles were published as of the year 2000 with one study but the largest number of publications occurred in 2013 with three publications. As for method, eight are qualitative articles, level of evidence 6 and three are reflexive, with level of evidence 7. No quantitative works were found that could help with concrete data that complements the qualitative work discourses.

In the results it was possible to observe that 100% of the studies recognize the violence in the childbirth as a problem. Four articles have also pointed out important results on other issues, two describe positive aspects of home births and two deal with gender violence as something present in the maternity and delivery environment.

DISCUSSION

Women are, still today, the majority in nursing and midwifery, this data is also remarkable, which may justify the predominance of papers published by nurses in the subject studied. Another point worth mentioning is the prevalence of gender studies written by women.

The objectives of the studies demonstrate the difficulty in working with the theme, since in only two, the word violence appears, in other other subjects such as humanization / dehumanization, childbirth care and the experience of women are found. The fact that the studies do not present the topic of violence in their objectives reinforces the authors' talk about obstetric violence as a veiled violence.^{7-6,14}

Violence in childbirth is also referred to in the articles as institutional violence, as it occurs in maternities, delivery rooms and hospital settings and is committed by health professionals who should be in these places ready to assist the parturients.

The articles point to institutional violence in maternity wards as a common and often banal practice, because it is not perceived and clearly defined. Abuse, use of aggressive and pejorative language, gross treatment, imposition and disrespect of autonomy, negligence in care, threats, excessive manipulation of the female body, such as

touches without necessity, excess use of medications, among others, are indicated as acts of violence.^{3,6-8,14-6}

Examples of excessive manipulation of the body are the practices of episiotomy, amniotomy, Kristeller's maneuver, enema, trichotomy, and routine fasting, which are pointed out as unnecessary and harmful practices during labor and delivery.^{9,17} The use of these interventions, when they do not have clear scientific evidence, can be considered violence against women.

These actions of violence generate others that interfere with the care and health of the parturient, such as excessive numbers of cesareans, the discouragement of normal birth, the fear of this natural process, the prevalence of pain and suffering, the creation of a depersonalized and solitary environment, which generates dissatisfaction for women and institutional violence, which interferes with maternal and infant morbidity and mortality.^{6,14,18-20}

As an explanation for the violent acts are pointed out the lack of an adequate structure, the precariousness of the health system, lack of material and human resources, as a result of the individual conduct of each professional, which involves ethical and moral aspects and the overload of services.⁷⁻⁸

This kind of violence has its roots in the history of the institutionalization of childbirth, which is no longer carried out in the homes, by relatives and midwives, to be assisted in maternity wards, by trained professionals, using technologies and medicines, but with the reduction of humanization.^{3,6,20-1}

In the articles found violence of various forms, sexual, physical, psychological and verbal are described. But a highlight is given to gender violence and the power relations existing between male domination over the female body, manipulation and medicalization of the body.

Gender violence is considered physical, sexual and psychological violence against women, manifesting itself through the historically and culturally unequal power relations between men and women.^{3:140}

The studies point to gender violence marked by relations of inequalities in the interactions between doctors / patients and by a relationship of power and domination. The exercise of power creates an environment of hostility and violence at the time of childbirth, in which the woman becomes passive of the professionals' decisions about their process of giving birth.^{6,8,14}

It is important to emphasize that violence is not restricted only to the medical professional, but it involves all the staff, including the nurse, as it is possible to observe in the speech:

It is also in this space, the preterm room that the hierarchical differences are sharpened, since, in the particular case of nursing, health professionals hold the power over the woman's body in labor, indicating what to do or even invading it without their permission.^{7:908}

Institutional violence is discussed as a veiled violence, that is, not perceived as such by the professionals involved, who often justify violent acts as necessary for the organization and conduct of labor. Women may not identify the facts as violent, because they are accustomed to reports from other mothers, have experienced previous experiences, failed to recognize the magnitude of these practices, and the forgetfulness caused by happiness in the presence of the child.^{3,7-8}

Some practices are considered effective and humane during labor and should be used by health professionals to guarantee a quality delivery. Examples are: the presence of the companion, the physical and emotional support, orientation on positions and movement, the pain management with non-pharmacological relief techniques (immersion or spraying baths, active ambulation, relaxation and breathing techniques, therapeutic touches and the use of Bobath's ball), epidural and spinal analgesia.^{9,17} Many of these actions are not performed with the parturient, even in the face of scientific evidence of its benefits and recommendations, contributing to women having a negative view of the process of giving birth.

As an initiative to reverse this situation of dehumanization and violence in childbirth, the humanization of care was pointed out as a primary strategy capable of generating a change of position and conduct of the professionals towards the woman in labor.^{3,8,20}

Humanization in childbirth aims to rescue the role of women as protagonists in the process of giving birth, to eliminate the use of unnecessary technologies, interventions and practices, to improve parturition and professional relationships, and above all to ensure a safe birth for the baby and its mother.²⁰⁻¹

In order to change this framework, the State has adopted Policies and programs, among which we can mention: the National

Humanization Policy (NHP) with focus on childbirth and birth, the Maternity Qualification Plan (MQP) and the Stork Network.⁹

The National Humanization Policy (NHP) conceptualizes humanization as the valuation of individuals involved in the health production process, emphasizing autonomy, protagonism, co-responsibility, establishing solidarity bonds and the collective participation of users, workers and managers.²²

The Prenatal and Birth Humanization Program (PBHP) precedes the NHP and was instituted by the Ministry of Health in the year 2000 with the objective of guaranteeing improved access, coverage and quality of prenatal care, and puerperium to pregnant women and the newborn.²³

The Maternity Qualification Plan was an action organized and coordinated by the National Humanization Policy (NHP) during the years 2009 to 2011, in an effort to guarantee more humane care, to qualify maternity wards and to improve perinatal care networks in the Legal Amazon and in the Northeast.²⁴

In order to expand the MQP throughout the country, CR was created in 2011, with the objective of offering institutional support to maternity wards and teams, with the perspective of producing quality maternal and child care networks that contain technical and financial incentives, to generate a change in the Brazilian obstetric and neonatal model.⁹

In the face of situations of violence, it is important to provide assistance to women as a whole, with health services provided by multi-professional care that can lead to a balance in the lives of those who have suffered violence.²⁵

As an initiative to train professionals involved in the pregnancy / puerperal cycle, the World Health Organization (WHO) and the Pan American Health Organization (PAHO) has identified a set of tools for the strengthening of obstetrics, with the main objective of reducing maternal and child mortality. Among the actions proposed is the development of quality curricula, capable of generating subsidies for the practice of safe motherhood. In this context, nursing and the specialization courses of these professionals are cited as fundamental for a change in the panorama of obstetrics and improvement of its indicators.²⁶

The nurse has been pointed out by public health policies as a professional capable of changing this reality of dehumanization and violence that the women and their concept live in. In order to achieve this goal, it must

strengthen its knowledge, so that based on the scientific evidence, it can face the adversities encountered, making appropriate and humane decisions, guaranteeing a satisfactory, happy, healthy birth process free from any type of iatrogeny.⁹

Much has been discussed today about the deinstitutionalization of childbirth, which many women and professionals have done, taking it back to the home. Studies have shown that this practice is justified by the woman's fear of being mistreated, of suffering, of being disrespected at this time, which must be the most beautiful and happy of her life. The professionals opt for this work because they do not accept the work dynamics of maternities and hospitals, which do not respect childbirth as something physiological.²⁰⁻¹

Studies comparing births performed at home and at hospitals have found similar indicators when gestation is low risk, evidencing that giving birth at home does not increase complications but rather guarantees greater maternal and family satisfaction.²⁰⁻¹

CONCLUSION

Violence in childbirth is a theme that has been discussed by professionals involved in the care of women in the puerperal pregnancy cycle. Knowing this process in detail with the perceptions of women, professionals and institutions is necessary for a thorough understanding of the real situation of the problem.

Studies have shown that women experience it and report it as unfavorable and harmful conditions of childbirth, but do not recognize such factors as violence. On the other hand, health professionals attribute inadequate behaviors to several factors, such as lack of physical structure, inadequate working conditions, the need to organize and control the service, and not as a relationship factor. Violence in childbirth is present in today's obstetric practices as something natural and difficult to change, linked to historical facts, cultural and gender violence.

As a strategy for change the humanization of care is pointed out as the most effective. But when we think that the Humanization Policy was instituted in the year 2000, we must reflect on its effectiveness and compliance, which over the years has not been sufficient for a real transformation of the assistance.

It is believed that the reversion of this situation depends on the awareness of professionals and especially women, so that

they can fight for their rights and guarantee a more humane and dignified assistance.

It was evident the need to develop new researches with this theme, which demonstrate the different meanings and perceptions of this subject, for all involved, women, family, diverse professionals and managers, since all articles have a weak level of evidence. Therefore the need to carry out research with larger and multicentric samples to improve care for women in childbirth and to implement public policies.

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