OBSTETRIC VIOLENCE IN THE MULTINATIONAL CONTEXT

A VIOLÊNCIA OBSTÉTRICA NO CONTEXTO MULTINACIONAL

LA VIOLENCIA OBSTÉTRICA EM EL CONTEXTO MULTINACIONAL

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ABSTRACT

Objective: to know the scientific production about obstetric violence. **Method:** integrative review of articles published from 2007 to 2016, sought in MEDLINE, Lilacs and the Scielo electronic library. The articles were selected through search with the descriptors: Childbirth, Normal childbirth, Humanized childbirth, Cesarean section, Pregnancy, Tocology, Labor and Violence, using the Boolean operators AND and OR as a tool to cross them. **Results:** twenty-nine articles were considered relevant and categorized in three types of violence, considering the similarity of content: institutional violence, moral/psychological/verbal violence, and physical violence. **Conclusion:** this review allowed us to understand that obstetric violence is present in different areas of care, confirming that the actions are still insufficient for its eradication. **Descriptors:** Women's Health; Childbirth; Natural Childbirth; Cesarean section; Tocology; Violence.

RESUMO

Objetivo: conhecer a produção científica acerca da violência obstétrica. **Método:** revisão integrativa, no período de 2007 a 2016, nas bases de dados MEDLINE, Lilacs e na biblioteca eletrônica Scielo. Os artigos foram selecionados por meio da busca com os descritores: Parto, Parto normal, Parto humanizado, Cesárea, Gravidez, Tocologia, Trabalho de parto e Violência, sendo utilizado os operadores booleanos AND e OR como ferramenta para o cruzamento destes. **Resultados:** foram considerados relevantes à temática deste estudo 29 artigos, categorizados em três tipos de violência considerando a similaridade de conteúdos, a saber: violência institucional, violência moral/ psicológica/ verbal e violência física. **Conclusão:** esta revisão permitiu perceber que a violência obstétrica se faz presente em diferentes âmbitos de cuidado, confirmando que as ações ainda são insuficientes para sua erradicação. **Descritores:** Saúde da Mulher; Parto; Parto Normal; Cesárea; Tocologia; Violência.

RESUMEN

Objetivo: conocer la producción científica acerca de la violencia obstétrica. **Método:** revisión integradora, en el período de 2007 a 2016, en las bases de datos MEDLINE, Lilacs y en la biblioteca eletrônica Scielo. Los artículos fueron seleccionados por medio de la búsqueda con los descriptors: Parto, Parto normal, Parto humanizado, Cesárea, Embarazo, Tocología, Trabajo de parto y Violencia, siendo utilizado los operadores booleanos AND y OR como herramienta para el cruzamiento de estos. **Resultados:** fueron considerados relevantes a la temática de este estudio 29 artículos, categorizados en tres tipos de violencia considerando la similitud de contenidos, a saber: violencia institucional, violencia moral/psicológica/verbal y violencia física. **Conclusión:** esta revisión permitió percibir que la violencia obstétrica se hace presente en diferentes ámbitos de cuidado, confirmando que las acciones aún son insuficientes para su erradicación. **Descriptor:** Salud de la Mujer; Parto; Parto Normal; Cesárea; Tocología; Violencia.

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INTRODUCTION

The medicalization of childbirth over the decades has become increasingly present in the female body and is mistakenly justified as necessary for a healthy delivery and reduction of the parturient's suffering.¹ In this context, the physiological event of giving birth and being born is understood as pathological, privileging the depersonalization and medicalization of the process with great damages to the support, stimulation and affection to women during the pregnant-puerperal cycle.²

In the perspective of humanization, it is believed that natural childbirth needs to be rescued and the high number of surgical deliveries decreased. Interventionist approaches need to be questioned and providers of health care of women from gestation to delivery need to be encouraged to reflect on their actions. Humanization of childbirth in Brazil has been proposed by the government not to revoke the technologies already achieved, but to avoid transforming a natural event into a medicalized or surgical phenomenon. It also aims to be a strategy for reducing maternal morbidity and mortality.³

In view of the exposed, studies on the subject of obstetric violence are sorely needed in order to qualify care strategies in the process of parturition with the less possible unnecessary interventions.

In this perspective, the present study is justified by the need to know the reality of obstetric violence in the world context in benefit of the empowerment of women to transform the current reality.

Based on the above, the following guiding question was prepared for this study: **What is the scientific production produced in the multinational scope addressing the theme obstetric violence in the period from 2007 to 2016?**

OBJECTIVE

♦ To know the scientific production about obstetric violence.

MÉTHOD

This is an integrative review study, what consists in a synopsis of several published studies that provide general considerations on a given area of study.⁴

The integrative review involved the following steps: 1) establishment of the hypothesis and objectives; 2) establishment of criteria for inclusion and exclusion of articles (sample selection); 3) definition of the information to be extracted from the selected

articles; 4) analysis of results; 5) discussion and presentation of results; and 6) presentation of the review.⁴ It is noteworthy that the whole process was permeated by the collective discussion and peer validation of the steps followed.

After the definition of the theme, the descriptors were chosen, namely, Parturition (*parto*), natural childbirth (*parto normal*), humanizing delivery (*parto humanizado*), cesarean section (*Cesárea*), pregnancy (*Gravidez*), midwifery (*Tocologia*), labor (*Trabalho de parto, obstetricia*), and Violence (*violência*), previously consulted in the Decs (Descriptors in Science and Health) and Mesh (Medical Subject Headings), using the Boolean operators AND and OR to cross them.

The search was performed on the Latin American and Caribbean Health Sciences Literature database (LILACS), *Scientific Electronic Library Online* (SciELO) and MEDLINE (Medical Literature Analysis and Retrieval System on-line).

The selection criterion was: manuscripts published in the English, Portuguese and Spanish that addressing obstetric violence and published in the last ten years.

The selection of the sample was performed by means of quick reading of the titles and abstracts, followed by reading the articles in full length.

RESULTS AND DISCUSSION

In the MEDLINE database, 103,878 publications were found with the descriptor Parturition; 2,833 with the descriptor Natural Childbirth; 36 with Humanizing delivery; 54,518 with Cesarean section; 867,174 with Pregnancy; 41,370 with Midwifery; 70,475 with Labor; and 95,687 with Violence. After crossing the descriptors, 5,011 publications were found, among which 12 addressed the theme selected in this study; the others covered aspects that did not meet the inclusion criteria.

In the LILACS database 12,153 publications were found with the descriptor Parturition; 348 with Natural Childbirth; 299 with Humanizing delivery; 3,074 with Cesarean section; 25,592 with Pregnancy; 116 with Midwifery; 724 with Labor; and 8,527 with Violence. After crossing the descriptors, 388 publications were found, among which 15 addressed the theme selected in this study; the others covered aspects that did not meet the inclusion criteria.

In SciELO, 2,863 publications were found with the descriptor Parturition; 91 with Natural Childbirth; 87 with Humanizing delivery; 370 with Cesarean section; 2,036 with Pregnancy; 16 with Midwifery; 71 with Labor; and 2,824 with Violence. After crossing the descriptors, 109 publications were found,

among which 2 addressed the theme selected in this study; the others covered aspects that did not meet the inclusion criteria.

At the end of the article selection, 29 articles were considered relevant to the theme of this study.

The expression "obstetric violence" was created by the current president of the Society of Obstetrics and Gynecology of Venezuela, Dr. Rogelio Pérez D'Gregorio. From then on, this expression has characterized the struggle of the movements of eradication of violence and penalties of violent attitudes and practices in the dynamics of parturition. The term was created in 2010 and was published in the International Journal of Gynecology and Obstetrics, when it was typified.⁵

To better organize the results of this review, we chose to divide the studies into three types of violence: institutional violence, moral/psychological/verbal violence, and physical violence.

◆ Institutional violence

Institutional violence is that practiced in public spaces, whether caused by action or omission of service providers. This violence ranges from poor quality of service to lack of access to it. It includes "abuses committed due to unequal power relations between users and professionals within institutions, even as the result of a narrower notion of intentional physical harm".⁶

A study carried out in Brazil in 2014, in the city of São Paulo, showed the experience of five obstetrician nurses in their actions and observations during their professional career in various workplaces, such as Basic Health Units, public and private hospitals and social health organizations. The nurses had graduated 05 to 36 years ago and reported having experienced acts practiced by obstetricians and nurses performing physical exams that did not offer privacy for the women, exposing them to other patients and to companions. Moreover, they did not allow the presence of the women's companions in the moment of labor and delivery. Obstetric nurses are also responsible, according to the study, for exposing names and diagnoses of patients on panels in the corridors of health services.⁷

In a study carried out in Rio de Janeiro, obstetric violence was indicated by the pilgrimage of women to obtain care in a specialized service. In some cases, pregnant women had to look for more than two public institutions in order to receive care.⁸

Although established and regulated by Law nº11,634 of December 27, 2007,⁹ the

transportation of pregnant woman to another public health facility should be assumed by units linked to the SUS (Unified Health System), and this displacement should occur safely and without cost to the patient. But this is not the predominant reality, turning what should be the beginning of a waiting period of months, i.e. the gestation, into a moment to be feared due to uncertainties, anguishes and risks.

Results similar to those already mentioned were found in a study carried out in Brazil, which demonstrated the pilgrimage of women in different maternities in search for quality care. The study demonstrated that when pregnant women finally receive assistance, they may face a lack of adequate structure, scarce or precarious human and physical resources, and may become a victim of institutional rules such as the prohibition of companions in the childbirth room or men in the room before childbirth. The latter prohibition is justified by lack of physical space, and the fact that the presence of men would take away the privacy of other pregnant women. There is therefore a lack of conditions for private care.¹⁰

Lack of privacy is also present in the study of several primiparous women, who reported the same situation. They revealed that they felt embarrassment during childbirth because there were many people in a room, most of them students coming and going all the time. Some have said it was a horrible experience, feeling bad with such a lack of privacy and respect.¹¹

Many educator professionals view as normal an exaggerated number of students during childbirth and ensure that such experience is necessary for the students' learning. However, it is understood that the dehumanization perpetuated by those who should be the role models for academics brings some discouragement, because the lesson passed in the above report shows physicians as holders of knowledge and the technical skill, being left to them the right to decide what is correct and necessary.

In the United Kingdom in 2009, a study that sought to explore the experience and personal meanings attributed to a traumatic birth reported the experience of women who had their companions prevented from sharing important moments for them.¹²

The same result was found in a study carried out in 2012, in Brazil, in a PhD thesis in which the main subject was the experience of unwanted cesarean sections. The study pointed out that although backed by law, the presence of companions is still denied, as

identified in different moments of the delivery process through the speeches of the puerperae.¹³

WHO recommends that all pregnant women should have a companion of their choice throughout the pregnant-puerperal cycle. The presence of a companion is protected in Brazil by Law N^o.11,108 of April 7, 2005.¹⁴ When Brazilian professionals disrespect a constitutional right, they are committing a crime, and any kind of justification is unacceptable.

It is well known that the continuous support of someone chosen by the women reduces labor time and makes them feel more confident and protected. Despite of it, many health care facilities still close eyes to scientific evidence, prevent companions from experiencing this event, and deprive women from the safety derived by the presence of a person of their own choice.

Another study points to structural problems in hospital facilities in Brazil, in 2015. The article shows that when walking through a public hospital, women see precarious conditions, such as the absence of water on a ward where the hospital places women who just had their babies. Dirt in the bathrooms was also mentioned; more than ten women shared the bathroom with another section. The dirt in the floor included mud and insects. The study also points to the pilgrimage of women to have access to obstetric beds and the lack of privacy suffered by women.¹⁵

The importance of personal hygiene during the postpartum period is well known. The exposure of women to invasive procedures predisposes them to possible puerperal infections. However, this is not what the findings of this review revealed, since in the revised studies it was possible to verify the lack of sanitation in health institutions, spaces that should give the example of care for health.

Lack of privacy suffered by women is again pointed out. One of the limitations is the prohibition of companions during childbirth, since hospitals do not have private rooms. The pilgrimage also occurred with many women due to the nurses' refusal to admit them to the hospital. One of the women was recommended to go home at night without being examined, and she lived more than 10 kilometers away from the hospital.¹⁶

Claiming that physical conditions are a reason to mistreatment sounds like an excuse because the violence goes far beyond that. No woman can be verbally disrespected, humiliated, constrained, deceived, be led to

accept procedures in result of lies told by professionals, or be exposed, discriminated, cut, squeezed, invaded, subjugated, abandoned, threatened, and deprived of their right of having a companion of her choice. All these actions are familiar to all women in maternity wards worldwide. These things transcend physical barriers. Not perpetuating violence, as well as not favoring indiscriminate interventionism, is something that health professionals vow.

♦ Moral, psychological and verbal violence

Moral violence is associated with the attitudes of professionals rather than with the rules of the institution, physical space, instruments and materials. According to Law 11.340/2006, in the article 7, moral violence is defined as "an action intended to slander, defame or injure the honor or reputation of women".¹⁰

Psychological violence is perceived "[...] when an individual is subjected to exposure of his body during care, being deprived of his privacy and disrespected in his cultural and religious values".¹⁷

In turn, verbal violence is directly linked to comments made by people with the intention of slandering and demeaning a woman, besides depriving her of recognizing her situation during the puerperal pregnancy period.¹⁰ This type of violence is related to moral and psychological violence.

In an article written in Brazil, the authors Regis and Resende (2015) performed a critical discursive analysis of a letter written to an obstetrician after four years of a birth that left many scars. In the letter, after being informed that she would need a cesarean, the woman asks if there is other way for having a natural birth, but the only thing the physician says is no, and sends her to the hospital. As she writes the letter, the woman begins to question the physician's attitudes and reports that she found it dishonest on the part of the obstetrician not to inform that she preferred to have a cesarean section, not making an effort to fulfill the patient's wishes and accused the physician of not being honest in telling what happened after her childbirth.¹⁸

It is understood that the women's participation in the decision-making process of their parturition process is extremely relevant in order for the delivery to be humanized and physiological. The share of women in the decision-making process is closely linked to their knowledge of the event of childbirth, as well as their empowerment to claim their rights, what would make them

able to even understand the reasons for a possible cesarean. However, many professionals still opt for omitting this information, arousing negative feelings in the women's experience of parturition.

Discrimination was a form of violence also found in a North American survey in 2015 that analyzed cases of mistreatment of parturients. This theme was recurrent in 13 studies from 10 countries of all geographic regions and different income levels, in which women were discriminated due to their ethnicity, race or religion.¹⁹

Discrimination based on socioeconomic status was found in 12 studies from 13 countries, but predominantly from sub-Saharan Africa. Women who experienced this type of discrimination reported that they have embittered their humiliation because of their poverty, their inability to read or write or because they do not live in rich areas, and suffered with negligence of health professionals.¹⁹

In turn, discrimination due to the age appeared in 7 studies from 5 countries and was experienced mainly by unmarried adolescents or older women who had had many children. These women were ridiculed and criticized. In South Africa, adolescents were so traumatized by the mistreatment that they claimed to have been advised to give birth to their children at home in future pregnancies. Depersonalization was also reported in 5 studies in which women reported having been deprived of their dignity during childbirth due to objectification of their bodies by health professionals and students.

The research also includes 31 studies showing that verbal abuse by health professionals is present in high, middle and low income countries. During childbirth, using rude and rough words was a commonly reported event. In addition, comments of sexual nature were reported in 10 studies, mostly in low-income countries; women were humiliated with rude comments when they were already in a vulnerable position during childbirth. However, 6 studies in richest countries showed health professionals threatening and blaming parturient women, implying that if they did not show good behavior, they would not be assisted or would have their babies mistreated, and there was even a report of threats of being beaten if they did not comply with an order.

It is discouraging to see professionals adopting discriminatory practices when they should rather be a shelter for women in such a situation of vulnerability. These actions need

to be rethought, because it is up to health professionals and their families to embrace the women without judgment and prejudice based on socioeconomic and ethnic conditions or on the choices of women.

In this perspective, a Brazilian study developed by Diniz et al in 2015 shows that maternal morbidity and mortality is compromised by obstetric violence in some ways, including verbal abuses and threats, and negligence from professionals when they assist women who express their suffering or who ask help with insistence because there is a widespread culture in the health services that women who scream, cry or are insistent receive a worse assistance. According to the article, women whose behavior is considered bad or who report dissatisfaction with care may suffer more with negligence.²⁰

In the United Kingdom, a survey with five women sought to identify how they approached maternity care services, as well as which were their expectations for the care they needed or wanted to receive. The authors pointed out that for this to happen, it is necessary that correct information be given, without the use of medical terminologies and jargons, besides the valuation by the professionals, as well as the knowledge and opinions of the women. However the study showed that such care does not occur with the research participants.²¹

Depriving pregnant/parturient women of correct information is a violence that ends up diminishing or destroying women's confidence in the professionals who should promote the feeling of safety. However, it is observed that many professionals still use the fragility in which the women are, because of fear of childbirth for lack of safe and clear information to have control over a situation in which the women should be the protagonists.

In 2016, a Brazilian study produced by Martins and Barros showed that women are depersonalized, dehumanized and treated as if they had no identity by health professionals, who refer to them as numbers, such as parity, centimeters of dilatation, or hospital record number. Another finding of this study was the denial of information and discriminatory and inhuman attitudes on the part of the professionals due to the difference of class, gender and race of the women. Abandonment and refusal of care is usual for women of less socially favored classes.¹⁰

In the same study, the authors report that many women authorize interventions based on partial or distorted information, or untruths told to them, such as incorrect information on dilation or fetal vitality, or recommendations

for cesarean sections due to meconium, macrosomia of the fetus, cord loops and very narrow pelvis. Coercive speeches during the birth of a moralistic and sexual content aimed at denigrating the woman are also reported, not to mention name-calling, hostility, shouting, ironic words and expressions, disrespectful comments and threats.¹⁰

This type of violence was portrayed in a study in Brazil, in 2013, with puerperal women and health workers. In the article, almost all respondents reported that they had used or witnessed the use of phrases of sexual connotation, lies and threats. These jocular, moralistic, and prejudiced phrases are very common in the day-to-day care to parturients. One of the obstetricians surveyed reported that she had already heard colleagues tell the patients to shut up and threat the patients of abandoning them; she herself confessed having already done this, although without the real intention to actually do this. But she pointed out that she has seen colleagues abandoning mother and baby, leaving them without care.²²

A Mexican study conducted in 2015 with 29 physicians aimed to identify the perception of obstetric violence and to determine its possible relation with the burnout syndrome or professional burnout. The survey showed that 35.71% of the interviewees stated they had already witnessed situations of medical negligence, the same percentile of physicians who witnessed discrimination based on age, race, or socioeconomic status. Rudeness, verbal attacks and denigrating phrases were experienced by 17.8% of the participants, and 10.7% mentioned omission, denial or lack of adequate information to patients.²³

Other form of violence that women undergo is related to contact with the baby after birth. In more than one report, the puerperae reported that soon after birth they waited for the baby to be placed in contact with them, but this did not happen.²⁴

In Brazil, a research carried out with 21 women who had their children in maternity hospitals in São Paulo showed disrespect on the part of the professionals through racial or social discrimination and coarse, impatient or indifferent treatment, as well as moralistic and disrespectful speech. Threats were also reported. One woman stated that she was told that if she did not keep quiet, they would abandon her. Another one heard from the nurse that she should keep quiet because physicians generally mistreat women when they cause trouble.²⁴

Study of an online journal in 2011 based on a South African report showed discrimination

experienced by women due to their health condition, xenophobia and disturbing reports of women who suffered various types of violence.²⁵

♦ Physical violence

Physical violence is defined by acts practiced that affect the body of women causing non-accidental damage with pain or physical damages, whether intense or not, without evidence-based support.²⁶

A study carried out in Brazil, in 2016, collected bibliographic data in search of the main types of obstetric violence suffered by Brazilian women in public health units. Physical violence included findings of violent or excessive vaginal touches, routine amniotomy, denial of analgesia, use of lithotomy position, Kristeller maneuver, use of forceps, episiotomy for training purposes, use of oxytocin without clinical indication, execution of procedures without the consent of the woman and cesarean surgeries to benefit the interests of medical professionals.²⁶

Similar results were found in a study conducted in São Paulo, in 2008, that showed the reports of women victims of violence through excessive, painful and unexplained vaginal touches without prior consent. The shame described by several of them, besides the pain due to the realization of touches in series showed the suffering lived by these women. In one of the lines, a woman reported that in less than one hour, about five people did the exam while more than ten were watching. After a while the whole process was repeated. At the end of the testimony, she reported that she thought that all this was normal.¹¹

A research conducted in 2010 showed that among the many forms of abuse, insensitivity and maltreatment, examination by painful touch and refusal by medical professionals to provide pain relief stood out. The authors mention that, according to official data, cesarean rates in public health establishments reach 52% and in the private sector they exceed 80%, figures not found anywhere else in the world.²⁷

A study corroborates data from the aforementioned authors and emphasizes that the complicated and problematic aspect of birth in Brazil is not only the result of high cesarean section rates, but also of other types of violence against women in the pregnant-puerperal cycle, failure to provide clear explanations on the procedures performed, verbal offenses such as shouting and cursing.¹⁸

In 2015, the WHO modified its guidelines on cesarean section, recognizing that the rates of this type of surgery have increased worldwide. Brazil, Mexico and the United States have cesarean rates higher than 30%, and Brazil is the world leader in this type of delivery.²⁸

Another type of violence pointed out by women is related to episiotomy. Participants complained that they were not aware of the practice of episiotomy in the hospital environment. A woman reported that she did not know that this was not part of the care provided in the hospital; she said that at the moment, she did not feel anything, but after some time she felt pain to the point that she could not feel her legs, but the physician told her that it was normal.²⁹

The lithotomy position was also mentioned in a Brazilian study. The authors said that students and residents negotiate among themselves who will perform an episiotomy for training purposes without the consent of the patient. They point out that women are chosen for the training of practices such as the use of forceps and even the realization of cesarean sections and in this logic, the authors reinforce that it is necessary to review the contents of all the health professions so that the practice of students be based on scientific evidence.²⁰

The article shows that obstetric violence has an impact on maternal morbidity and mortality in the case of aggressive management of vaginal delivery. This is associated with denial of anesthesia, or overuse, as well as often non-informed or consented use of oxytocin, kristeller maneuver and forceps.²⁰

In the United States, among the abuses there was treatment and consultations without informed consent, and practices such as administration of oxytocin until the baby starts suffering. Some women are treated with extreme hostility, including denial of pain relief and sexual abuse. The author states that rates for various harmful practices such as the use of oxytocin, induction of cesarean surgeries, and episiotomy have increased.³⁰

As most of the times, all these procedures can be avoided and that most of them have no clinical recommendations, it is evident that women suffer violence when they go to the hospital for the long awaited day, the birth of their children. By intervening in something innate, the professionals end up destroying dreams and expectations created for many months.

A study analyzing the reports observed a coercive dynamics on the part of the

professionals to perform a cesarean section, among them the threat that if women did not obey they would put the life of the babies and of mothers at risk, disrespect for the desires and choices of the pregnant women, imposition of painful procedures without the correct relief of pain, conditioning of the end of the suffering to the acceptance of a cesarean surgery, the false impression that they could go through all the labor and still later need a cesarean section and the conviction that, if the delivery is by vaginal route, it may happen that there are no professionals as an anesthetist or pediatrician at the moment or even that these professionals will be unknown to the obstetrician.¹³

The author shows other types of violence, such as the kristeller maneuver, the use of forceps, lack of explanation of procedures for the patients, lack of request for the parturients' consent to perform certain procedures, acceleration of labor through oxytocin infusion and deprivation of food during the labor. She concludes that "the choice is respected when the desire is for a cesarean section, but not when the desire is for normal delivery".¹³

The study that used two research scenarios, namely, a preparation group for humanized childbirth and a documentary, reinforces the violence suffered by women in the pregnant-puerperal cycle, such as deliveries for the convenience of date for physicians, thus avoiding weekends, hours night and holidays.³¹

In the same study, another puerperal woman reported that the worst of all had been the episiotomy, which caused an inflammation. She said that she felt violated, raped and strange and did not like it when her husband touched that region. Until the day of the interview, she felt itch in the stitches. According to the woman, the episiotomy affected her sexuality to a great extent and how she dealt with her own body.³²

Narratives of violence and disrespect such as these at the time of delivery are recurrent and range from not performing a procedure desired by the woman, such as analgesia for pain, eating and walking in the hospital, up to unwanted practices such as episiotomy, shaving, intestinal lavage, verbal and moral offenses, administration of intravenous oxytocin that cause severe discomfort, emotional pressure to anticipate labor, cesarean sections and scars.

A study conducted in 2013 emphasized that the women were unaware of the reason they were subjected to some procedures and

reported that episiotomy and the use of synthetic oxytocin was necessary. In one of the statements, the woman said that the delivery was very difficult and luckily a woman perched on her belly. Another woman reported that upon arriving at the hospital with 7 cm of dilation, her amniotic sac was punctured by the physician who told her to lie down. When he went to examine her, he told the woman that what he was going to do was not going to hurt her; that she stayed calm, but she said to have felt a lot of pain with the vaginal touch.²⁴

Obstetricians interviewed in this study said that practice shows that it is much better to suture an episiotomy than a tear, that is, a laceration. However, another obstetrician affirms that he never does an episiotomy and clarifies that this practice has four indications in the world that are infrequent enough to occur, so that he does not perform it and reveals that in 94% of deliveries there is no real indication to do it.²⁴

The culture of domination of medical knowledge is rooted in many women, who believe that they owe obedience and eternal gratitude to these professionals. This is one of the reasons why workers in obstetric health use so many unnecessary interventions, because by doing so they make themselves essential in the care, even though such need is a lie told through violence and savagery.

In the United States, a study comparing results in 13 facilities in Kenya after training of care providers showed that nonconsensual care was common at the start of the study (61%), but rose to higher end-line levels (81%). Physical aggression during labor and delivery decreased considerably, changing from 3.8% in the baseline to 0.4%. The study found that women with better purchasing power were more likely to report physical abuse. In addition, women who had a child at night suffered 2.5% more physical abuse than those who gave birth during the day.³²

In Mexico, a survey of 29 obstetrical physicians working in different institutions and hospitals in Puebla indicated that more than 35% of the participants had already witnessed harmful practices such as cesarean section and episiotomy with no clinical indication and 17.8% reported situations in which the patients were ignored despite reporting pain.²³

In Brazil, a study produced by Andrade et al. in 2016 with 522 people had as objective to analyze the factors related to obstetric violence specifically regarding non-recommended practices in vaginal delivery in

a maternity school of reference of the city of Recife.³³

This study found that 87% of the patients had suffered some type of violence during labor and delivery, with the most common practices being forceful attempted exhalation (65%), administration of oxytocin (41%) and routine use of lithotomy/supine (39%). The authors pointed out other data: 31% of women had early amniotomy, 30% had early clamping of the umbilical cord, 19% had active fetal manipulation/repetitive vaginal touches, 11% had water and food restriction in labor, 10% underwent rectal examination, 9% were victims of Kristeller's maneuver and 2% were subjected to episiotomy.³³

It is important to note that the work also questioned good practices in maternity and 95% of women had the right of companions respected, 93% had the support of professionals in labor and 89% of parturients were respected in their privacy.³³

In a Brazilian study, 21 puerperal women were interviewed in the city of São Paulo. Testimonies of brutality at the moment of vaginal touch were verified, as well as reports of professionals who punctured the amniotic sac of pregnant women without clinical indication. Performing episiotomy, non-consented exams, interventions performed without negotiation or explanation, besides the professionals' denial of providing pain relief for pregnant women are also found in the article.²²

Finally, a publication from Argentina begins by showing that the views on obstetric violence among women and medical professionals are divergent. In order to systematize the different views, the article reported on the attitude of obstetricians in the face of humanized childbirth. These attitudes resulted in the start of the implementation of a federal program in Mexico that included obstetricians, non-specialized physicians and homeopaths aiming at practices of humanized childbirth.³⁴

CONCLUSION

This integrative review allowed knowing the national and international scientific production on obstetric violence in the period from 2007 to 2016. It was evidenced that the year 2015 had the largest number of publications on the subject, Brazil being the country with the highest number of researches.

We observed that obstetric violence is no longer ignored in discussions, with repercussions on the increase in cases reported in publications.

Obstetric violence in the world is present in various forms and in various health facilities. Health professionals are trained in different educational contexts. Remodeling/changing the way of teaching, emphasizing ethics, the willingness to do better and applying scientific evidence in obstetric care are good principles for practical obstetric qualification.

At the conclusion of this study, the following question arises: "Is it possible to change the situation of obstetric violence worldwide?" After all, despite the worldwide efforts, this review pointed out that obstetric violence is present in different areas of care, confirming that the actions are still insufficient for its eradication.

However, we believe that it is possible to change this scenario. First, it is necessary to rethink the teaching/practice of medical professionals and nurses who often teach and practice archaic knowledge and students end up reproducing such practices, showing a setback in the process. It is necessary to reinforce in teaching and in practice that the humanization of care must horizontally permeate the curricula of the faculties of health courses.

In addition to the aforementioned aspects, it is fundamental to work on empowerment of women regarding the safe and natural practices of parturition, so that they recognize violence, denounce and demand the qualified care to which they have the right.

At the end of this study, the aim is to awaken reflections and deepen and generate new knowledge about obstetric violence, its advances and setbacks worldwide. We believe that there is a need for further studies in the knowledge and recognition of the problem, as well as the awareness of women and health professionals regarding the issue of obstetric violence.

REFERENCES

1. Silva EC; Santos IMM. A percepção das mulheres acerca da sua parturi(a)ção. *Rev pesqui cuid fundam* (Online). 2009;1(2):111-23. Doi: 10.9789/2175-5361.2009.v1i2.%p
2. Castro JC; Clapis MJ. Parto humanizado na percepção das enfermeiras obstétricas envolvidas com a assistência ao parto. *Rev Lat Am Enfermagem*.2005;13(6):960-967. Doi: <http://dx.doi.org/10.1590/S0104-11692005000600007>.
3. Cechin PL. Reflexões sobre o resgate do parto natural na era da tecnologia. 2014.
4. Mendes KDS, Silveira RCCP, Galvão CM. Revisão integrativa: método de pesquisa para a Incorporação de evidências na saúde e na enfermagem. *Texto & Contexto Enferm*. 2008;17(4):758-64. Doi: <http://dx.doi.org/10.1590/S0104-07072008000400018>.
5. Mariani AC, Neto JON. Violência de gênero e violência institucionalizada: breves considerações a partir dos direitos humanos e do respeito às mulheres. *Cad esc dir rel int*(UNIBRASIL).2016;2(25):48-60.
6. Ministério da Saúde (BR). Humanização do parto e do nascimento. Universidade Estadual do Ceará - Brasília; 2014. 465 p.
7. Phillips E, McGrath P, Vaughan G. 'I wanted desperately to have a natural birth': mothers' insights on vaginal birth after Caesarean (VBAC). *Contemp Nurse*. 2009;34(1):77-84. PMID: 20230174
8. Rodrigues DP; Alves VH; Penna LHG; Pereira AV; Branco MBLR; Silva LA. A peregrinação no período reprodutivo: uma violência no campo obstétrico. *Escola Anna Nery Revista de Enfermagem*.2015;19(4):614-620. Doi: 10.5935/1414-8145.20150082
9. Ministerio da Saúde (BR). Câmara dos Deputados. Lei nº 11.634, de 27 de dezembro de 2007. Dispõe sobre o direito da gestante ao conhecimento e a vinculação à maternidade onde receberá assistência no âmbito do Sistema Único de Saúde. Dispõe sobre o direito da gestante ao conhecimento e a vinculação à maternidade onde receberá assistência no âmbito do Sistema Único de Saúde. Brasil: Distrito Federal, 2007.
10. Martins AC; Barros GM. Parirás na dor? Revisão integrativa da violência obstétrica em unidades públicas brasileiras. *Rev dor*.2016;17(3):215-8. Doi: <http://dx.doi.org/10.5935/1806-0013.20160074>
11. Wolff LR; Waldow VR. Violência consentida: mulheres em trabalho de parto e parto. *Saúde soc*.2008;17(3):138-51. Doi: <http://dx.doi.org/10.1590/S0104-12902008000300014>
12. Thomson G; Downe S .Widening the trauma discourse: the link between childbirth and experiences of abuse. *J psychosom obstet gynaecol*.2008;29(4):268-73. PMID: 19065396
13. Salgado HO. A experiência da cesárea indesejada: perspectivas das mulheres sobre decisões e sus implicações no parto e nascimento [tese].São Paulo (SP):Universidade de São Paulo;2012.
14. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Pré-natal e puerpério: atenção qualificada e humanizada: manual técnico. Brasília;2005.

15. Carneiro R. To go past the Bojador, one must go beyond pain": labor suffering and its potencial. *Sex salud soc.*2015;1(20):91-112.

Doi: <http://dx.doi.org/10.1590/1984-6487.sess.2015.20.08.a>

16. Sánchez SB. Obstetric violence: Medicalization, authority abuse and sexism within Spanish obstetric assistance. A new name for old issues? [tese]. Países Bajos (NL):Utrecht Universiteit; 2014.

17. Díaz CB. Federación de Asociaciones de Matronas de España. La maniobra de Kristeller: revisión de las evidencias científicas. *Matronas prof.*2011;12(3):82-9. Doi: <http://dx.doi.org/10.1007/s00404-009-1246-2>. 21

18. Regis JFS; Resende VM. Then you delivered my daughter": critical discourse analysis of a letter to the obstetrician. *DELTA: Documentação de Estudos em Linguística Teórica e Aplicada.*2015;31(2):1-30. Doi: <http://dx.doi.org/10.1590/0102-445000967380245314>

19. Meghan A; Bohren JP; Vogel EC; Hunter OL; Suprita K; Makh JP; et al. The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLOS Medicine.*2015;1(1):1-30.

Doi:<https://doi.org/10.1371/journal.pmed.1001847>

20. Diniz CSG. Humanização da assistência ao parto no Brasil: os muitos sentidos de um movimento. *Ciênc Saúde Coletiva.*2005;10(3):627-37. Doi:

<http://dx.doi.org/10.1590/S1413-81232005000300019>

21. Jones CB; Breckenridge JP; Devaney J; Kroll T;Lazenbatt A; Taylor J. Disabled women's experiences of accessing and utilising maternity services when they are affected by domestic abuse: a critical incident technique study. *BMC Pregnancy Childbirth.*2015;15(1):181-89.

Doi: <https://doi.org/10.1186/s12884-015-0616-y>

22. Aguiar JM; D'Oliveira AFPL; Schraiber LB. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde. *Cad Saude Publica.*2013;29(11):2287-96. Doi: <http://dx.doi.org/10.1590/0102-311x00074912>

23. Pintado-Cucarella S; Penagos-Corzo JC; Casas-Arellano MA. Burnout syndrome in medical and obstetric perception of violence. *Ginecol Obstet Mex.*2015;83(3):173-8. PMID: 26058170

24. García-Jordá D; Díaz-Bernal Z; Acosta Álamo M. Childbirth in Cuba: analysis of the experience of medically supervised delivery from an anthropological perspective. *Ciênc saúde coletiva.* 2012;17(7):1893-1902. Doi: <http://dx.doi.org/10.1590/S1413-81232012000700029>

25. Barros FC; Victora CG; Barros AJ; Santos IS; Albernaz E; Matijasevich A; et al. The challenge of reducing neonatal mortality in middle-income countries: findings from three Brazilian birth cohorts in 1982, 1993, and 2004. *The Lancet.*2005;365(9462):847-854, 2005. Doi: [10.1016/S0140-6736\(05\)71042-4](https://doi.org/10.1016/S0140-6736(05)71042-4)

26. Santos ML. Humanização da assistência ao parto e nascimento. Um modelo teórico. [dissertação]. Florianópolis (SC):Universidade Federal de Santa Catarina, Florianópolis;2002.

27. Sanfelice CFO; Shimo AKK. Parto domiciliar: avanço ou retrocesso?.*Rev gaúch enferm.*2014;35(1):157-160. Doi: <http://dx.doi.org/10.1590/1983-1447.2014>.

28. Organização Mundial da Saúde (OMS). Declaração da OMS sobre taxas de cesáreas. 2015.

29. Yaiahuanca A; Socorro RD. A experiência de gravidez, parto e pós-parto das imigrantes bolivianas e seus desencontros na cidade de São Paulo - Brasil. [tese]. São Paulo (SP): Universidade de São Paulo;2015.

30. Susan Hodges MS. Abuse in Hospital-Based Birth Settings? *J Perinat Educ.* 2009;18(4): 8-11. Doi: [10.1624/105812409X474663](https://doi.org/10.1624/105812409X474663)

31. Carneiro R. To go past the Bojador, one must go beyond pain": labor suffering and its potencial. *Sex Salud Soc (Rio J).*2015; 5(8): 91-112. Doi: <http://dx.doi.org/10.1590/1984-6487.sess.2015.20.08.a>

32. Abuya T;Ndwiga C; Ritter J; Kanya L;Ben Bellows, Nancy Binki, Charlotte E. Warren. The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya. *BMC Pregnancy and Childbirth.*2015. Doi: <https://doi.org/10.1186/s12884-015-0645-6>

33. Andrade PON; Silva JQP;Diniz CMM; Caminha MFC. Factors associated with obstetric abuse in vaginal birth care at a high-complexity maternity unit in Recife, Pernambuco.*Rev bras saúde mater infant (Online).*2016;16(1):29-37. Doi: <http://dx.doi.org/10.1590/1806-93042016000100004>

34. Pozzio MR. La gineco-obstetricia em México: entre el "parto humanizado" y la violencia obstétrica. *Rev Estud. Fem [online].* 2016;24(1):101-17.Do: <http://dx.doi.org/10.1590/1805-9584-2016v24n1p101>.

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