ABSTRACT

Objective: to reveal the forms of obstetric violence suffered during pregnancy and childbirth from reports of puerperal women. Method: exploratory, descriptive study, with a qualitative approach, performed with 41 mothers in the Family Health Services. Data were produced through interviews and submitted to the Content Analysis Technique in the Thematic Analysis modality. Results: this study revealed the following thematic categories: “Types of obstetric violence experienced during pregnancy and childbirth” and “Repercussions of obstetric violence on women’s lives and the main professionals involved”. Conclusion: pain, repetitive and abusive exams, maneuvers without scientific evidence of any benefit and neglect are the main forms of obstetric violence. Descriptors: Nursing; Obstetric Violence; Gender Violence; Puerperium.

RESUMO
Objetivo: desvelar as formas de violências obstétricas sofridas durante a gestação e o parto a partir de relatos de puérperas. Método: estudo exploratório, descritivo, com abordagem qualitativa, realizado com 41 puérperas nas Unidades de Saúde da Família. Os dados foram produzidos por meio de entrevistas e submetidos à Técnica de Análise de conteúdo na modalidade Análise Temática. Resultados: o estudo revelou as seguintes categorias temáticas: “Tipos de violência obstétrica vivenciados na gestação e no parto” e “As repercussões da violência obstétrica na vida das mulheres e os principais profissionais envolvidos”. Conclusão: observou-se que a dor, exames abusivos repetitivos, manobras sem evidências científicas de qualquer benefício e o descaso são as principais formas de violência obstétrica. Descriptors: Enfermagem; Violência Obstétrica; Violência de Gênero; Puerpério.

RESUMEN
Objetivo: desvelar las formas de violencias obstétricas sufridas durante la gestación y el parto a partir de relatos de puérperas. Método: estudio exploratorio, descritivo, con enfoque cualitativo, realizado con 41 puérperas en las Unidades de Salud de la Familia. Los datos fueron producidos por medio de entrevistas y sometidos a la Técnica de Análisis de contenido en la modalidad Análisis Temática. Resultados: el estudio reveló las siguientes categorías temáticas: “Tipos de violencia obstétrica vividos en la gestación y en el parto” y “Las repercusiones de la violencia obstétrica en la vida de las mujeres y los principales profesionales involucrados”. Conclusión: se observó que el dolor, exámenes abusivos repetitivos, maniobras sin evidencias científicas de cualquier beneficio y el descaso de las principales formas de violencia obstétrica. Descriptores: Enfermería; La Violencia Obstétrica; La Violencia de Género; Posparto.

1Nurse, PhD Professor of Nursing, Faculty of Medical Sciences of Paraíba, João Pessoa (PB), Brazil. E-mail: laa_8@hotmail.com; 2Nurse, PhD Professor of Nursing, Faculty of Medical Sciences, Paraíba (UFPB). João Pessoa (PB), Brazil. E-mail: kamylaoliveira@hotmail.com; 3Nurse, Speech Therapist, PhD Student in Nursing, Federal University of Paraíba, Faculty of Medical Sciences, Paraíba (UFPB). João Pessoa (PB), Brazil. E-mail: cristiani_garrido@hotmail.com; 4Nurse, PhD in Nursing, Faculty of Medical Sciences, Paraíba (UFPB). João Pessoa (PB), Brazil. E-mail: fabianabrito@hotmail.com; 5Nurse, PhD Professor of Nursing, Faculty of Medical Sciences of Paraíba, João Pessoa (PB), Brazil. E-mail: belle_costa@hotmail.com; 6Nurse, PhD Student in Nursing, Faculty of Medical Sciences, Paraíba (UFPB). João Pessoa (PB), Brazil. E-mail: cristiani_garrido@hotmail.com; 7Nurse, PhD Professor of Nursing, Faculty of Medical Sciences, Paraíba (UFPB). João Pessoa (PB), Brazil. E-mail: laa_8@hotmail.com; 8Nurse, PhD Professor of Nursing, Faculty of Medical Sciences, Paraíba (UFPB). João Pessoa (PB), Brazil. E-mail: kamylaoliveira@hotmail.com; 9Nurse, PhD Professor of Nursing, Faculty of Medical Sciences, Paraíba (UFPB). João Pessoa (PB), Brazil. E-mail: fabianabrito@hotmail.com.
INTRODUCTION

In the past, the process of giving birth was seen as something natural, and pain as God’s punishment. Parturitions took place in women’s homes, where mothers received support from other women living nearby or from their families, who shared their own experiences and helped during labor.¹

With the emergence of new scientific technologies and the medicalization of the female body, pregnancy, childbirth, and birth, hitherto regarded as a family event, have become a technological and hospitalized event in which the physician emerges as the leading figure, aiming to control risk situations for mother and child.² In this sense, the physician began to assume all responsibility and to have total autonomy in the parturition process, taking all decisions about the progress of the process and the therapeutic measures to be used, regardless of the mother’s will, who happened to be a submissive subject in face of all the hegemony presented by the driver of the birth.³

In order to better inform professionals, in 1996 the World Health Organization (WHO) created a manual on best practices in care during labor and childbirth, divided into four categories: demonstrably useful practices that should be encouraged; clearly harmful or ineffective practices, which must be eliminated; practices without sufficient evidence to support a clear recommendation and that should be used with caution until more research clarifies the issue; and often inappropriately used practices.⁴

Over the years, the Ministry of Health has developed strategies aimed at a new model of childbirth care, seeking to care for women in a humanized way and abruptly reducing unnecessary interventions. In this perspective, in 2002, the Ministry of Health, through Ordinance/GM No. 56, of 6/1/2000, established the Humanization Program for Prenatal Care and Birth, whose main objective is to ensure the improvement of access, coverage and quality of prenatal monitoring, delivery care and puerperal period for pregnant women and newborn, with a view to citizens’ rights.⁵

There have been restructurings and new adaptations to the humanization policy in many health services in Brazil, but the high rates of unnecessary obstetric interventions are still predominant.⁶ During labor, the woman experiences painful contractions, low back pain, breathing difficulties and her feelings are intensified, such as fears and insecurities. This woman needs to be assisted by a professional who respects her beliefs, reports and that hears, advises and supports from prenatal period to the end of gestation, extending such care also to the delivery period.⁷

It is vitally important to broaden the discussion about violent ways of providing assistance to this population. Thus, initially, it is necessary to understand the conceptual aspects of violence that is defined as the modification of a difference in inequality in a hierarchical relationship aiming to oppress the other that is object of action, having its autonomy, subjectivity and free action annulled. On the other hand, some authors define that violence can also imply in the annulment of actions, leading to the use of force, coercion or destruction in a search for self-assertion.⁸

Obstetric violence, in turn, is characterized by all acts committed against women in the exercise of their sexual and reproductive health. They can be perpetrated by health professionals, public servants, technical-administrative professionals from public and private institutions, as well as civilians. They may have physical, psychological, sexual, institutional, media and material characteristics.⁹

It should be noted that a survey revealed that “one in four Brazilian women who gave birth in public or private hospitals reported some type of aggression during childbirth.”¹⁰ⁱ²

Aggressive behaviors such as use of foul language, shouting, oppression, unnecessary procedures such as episiotomy, use of forceps and other maneuvers not recommended by the manual on best practices, are frequent, especially in the Brazilian scenario where obstetric violence is quite expressive. However, this issue is still little approached in scientific production. According to information from the São Paulo Public Prosecutor’s Office, obstetrics is the medical area with the highest number of infractions worldwide.¹¹

Given the above and considering the relevance of this topic, disclosing the reports of women who suffered some kind of obstetric violence, either at the time of delivery, during prenatal consultations and in the postpartum period is necessary in order to elucidate and better understand the subjectivity that surrounds this problem, thus raising students and health professionals’ awareness, with emphasis on Nursing, corroborating to the reformulation of practices of the obstetric scenario and the concretization of humanization policies. Thus, the present study aims to:
• Uncover the forms of obstetric violence suffered during pregnancy and childbirth from reports of puerperal women.

METHOD

This is an exploratory, descriptive study, with qualitative approach. The research scenario was the municipality of Cabedelo, in Paraíba State. This municipality is a medium-large urban center of the Mata Paraibana mesoregion, which has a population estimated at 64,360 inhabitants, of which, according to the Brazilian Institute of Geography and Statistics (IBGE), 33,360 are women,\(^\text{12}\) and it encompasses 20 family health units (FHU).

The study population consisted of an average of 906 postpartum women, according to data from the State Department of Health, available in the Information System for Live Births (SINASC in Portuguese), belonging to the municipality of Cabedelo (PB), Brazil. The 5% proportional stratified sampling of each FHU was selected with the aim of involving the proportion of the size of each stratum of the puerperal population of all units of the said municipality, thus totaling a sample of 45 participants. The inclusion criteria were: being in the puerperal period, as recommended by the Ministry of Health; older than 18 years; having cognitive ability to answer the research questions; and being a user of one of the family health units of the selected municipality. Due to the fact that the questionnaire included questions that lead to embarrassment and concern about portraying the issue of violence, four puerperal women did not answer some questions, which is why they were excluded from the study. Thus, the final sample consisted of 41 postpartum women.

Puerperium begins one to two hours after the exit of the placenta and has its unexpected end, because while the woman breastfeeds she will be undergoing modifications of the gestation (lactation), in which her menstrual cycles will not return completely to normality. The Ministry of Health thus legally divides the puerperium into: immediate (1st to 10th day), late (11th to 42nd) and remote (from the 43rd day).\(^2\)

Data collection was performed at the FHU of Cabedelo (PB), Brazil, from March to May 2015, in private rooms, to guarantee the confidentiality and anonymity of the participants. Information about socioeconomic and gynecobstetric data was collected using a structured instrument; then, data regarding the objectives proposed for this study were collected through an interview script, with the help of an audio recorder.

The interviews were transcribed in full, respecting the informality of the speech. To maintain the anonymity of the participants, the statements were referenced by the letter P (from puerperal woman), followed by numbers from one to 41 (P1, P2... P41).

The treatment of the data occurred through the technique of content analysis. Analysis was divided into three stages: a) pre-analysis; B) exploration of the material; and c) treatment of results, inference and interpretation.\(^13\)

The researcher respected the ethical and legal aspects of the research involving human beings, as recommended by Resolution 466/12 of the National Health Council\(^14\), especially the ethical principle of autonomy and, above all, to the free and informed consent form. The research was approved by the Research Ethics Committee of the Faculty of Medical Sciences of Paraíba (CEP/FCMPB), under protocol No. 981.841 and Certificate of Presentation for Ethical Appreciation 40969015.3.0000.5178.

RESULTS AND DISCUSSION

Regarding the characterization of the puerperal women, they were in the adult age range, between 18 and 35 years of age. Regarding marital status, 8 (20%) were married, 7 (17%) were single and 26 (63%) lived in stable union with their partners. As to the level of schooling, 18 (44%) had completed high school, 21 (51%) had completed primary school and only 2 (5%) had a college degree.

Regarding the number of births, 16 (39%) were multiparous and 25 (61%) were primiparous, 8 (20%) of whom had had at least one miscarriage. Regarding the type of delivery of puerperal women, 17 (41%) had normal delivery, 20 (49%) cesarean section and 4 (10%) women had had both types of delivery.

Concerning the questions that portray the object of the study, 7 (17%) of the 41 interviews, vehemently denied having experiencing any type of obstetric violence and 34 (83%) revealed that they had already suffered it, however, of these, 16 (39%) women started the interview denying and, as they were responding to the questions, they unveiled and/or discovered that they had already suffered some kind of maltreatment, but did not understand it as violence.

Regarding the types of violence, 4 (10%) women reported having suffered some aggression and 15 (37%) had suffered violence in two or more ways. The most mentioned
Types of violence were: 4 (10%) Kristeller's maneuvers; 12 (29%) absence of pain relief techniques; 9 (22%) neglect; 8 (20%) invasive, constant or aggressive digital vaginal examinations; 5 (12%) the use of episiotomy without informed consent; and 3 (7%) deprivation of liberty to the companion. As to the main professionals involved during obstetric violence, physicians were mentioned by 9 (22%) of the interviewees, nurses by 5 (12%) of the women and 20 (49%) were not able to identify the role of professionals in the moment of aggression.

The analysis of the empirical data gave rise to two thematic categories: "Types of obstetric violence experienced during pregnancy and childbirth" and "Repercussions of obstetric violence on women's lives and the main professionals involved".

† Types of obstetric violence experienced during pregnancy and childbirth

Obstetric violence is still little understood as a violent act, because concomitantly to its occurrence, women are experiencing remarkable emotions that permeate pregnancy, childbirth and puerperium, which, in many cases, makes them be silent. In this context, unveiling about this type of violence is complex, since it involves several psycho-emotional aspects that initially can generate feelings of fear, insecurity, negative memories, and abstaining from this situation may be the best choice not to face and remember these moments that bring anguish and fear. However, disclosing the various types of obstetric violence that permeate health care institutions is necessary, whether they involve physical, psychological, sexual, institutional, media or material aspect in order to raise the community and professionals' awareness to fight against this practice that causes various repercussions and disorders in women's lives.

Concerning obstetric violence involving the physical aspect, it comprises actions that occur on the woman's body, interfering, causing pain or physical damage (from mild to intense), without recommendation based and proven by scientific evidence, such as food deprivation, interdiction of the woman's movement, trichotomy, Kristeller's maneuver, routine use of oxytocin, elective cesarean section without clinical indication and no use of analgesia when technically indicated. A Manobra de Kristeller foi citada por 4(10%) das entrevistadas conforme vislumbrado nos discursos a seguir:

Report of puerperas about obstetric...

[...] They pushed my belly [...] it hurt. (P8 and P16)
A physician pushed him hard under my rib; he forced the boy to get out. (P14)
In the cesarean room, they pushed my belly. (P15)

A national study that used data from the survey Nascer no Brasil (Being Born in Brazil), with a hospital base in 2011/2012, with 23,894 women, verified that the Kristeller's maneuver had been performed in 37% of the women. These values are still quite expressive because it is a practice that should be avoided as routine use.

Study on scientific evidence at Cochrane database failed to prove the benefits of this practice since the potential risks with its use include uterine rupture, anal sphincter injury, fractures or brain lesions in newborns and increased blood transfusion between the mother and her baby. This can be important as a triggering factor for serious problems, especially when the mother has HIV, hepatitis B or other viral disease.

This approach to pressure on the uterine fundus falls within group C of the WHO Manual as practices without sufficient evidence to support a clear recommendation and that should be used with caution until more research clarifies the issue.

Regarding physical aggression, reports of pain were also mentioned by 12 (29%) of the puerperal women as well as the non-use of relief techniques when requested and/or recommended. The strong impact caused by pain in women is described in the following statements:

I felt a lot of pain and they only gave medicine to increase the pain. (P3)
I felt a very strong pain. I asked them to give something and they did not. (P4)
I started to feel pain at midnight. At six o'clock in the morning I had three centimeters and they did nothing for me. (P6)
I felt a lot of pain. I asked for something to relieve it and they did not give; they only gave me an injection, only in the end. (P7)

The pain of childbirth is part of human nature itself, and unlike other acute and chronic painful experiences, it is not associated with pathology, but rather with the experience of generating a new life. However, some women find that it is the worst pain felt. In view of these aspects, it becomes evident that actions must be taken to reduce the level of stress and anxiety of women during labor, related to pain. Pain involves a multidimensional phenomenon that can be approached by means of pharmacological techniques, which should be used with caution, and non-pharmacological
techniques, which are stimulated even by WHO for the use of all professionals.

Among the non-pharmacological techniques, research of scientific evidence reveals how effective massages in the lumbar region, aromatherapy, use of low voltage switchgear, such as TENS, soaking baths, breathing exercises, muscle relaxation, support measures for maternal comfort, among others, can be. However, even in the face of all these strategies, the lack of pain management is evident in the reports, not only referring to the lack of analgesia when requested, but it also appears when health professionals despise the feelings of the mothers, as evidenced in the statements:

[…] Then she (the physician) said: “You are faking!” And I was almost dying in pain and she just said that I was faking. Even in the delivery room, I heard, even though I was under anesthesia, she said, “I knew something was going to happen to this woman; I brought her here, but I knew she was not going to have it.” And she screamed at me, all the time screaming, she took me into the delivery room screaming that I was faking, that I would not put the boy out because I did not want to. I had no more strength, only God could help me at that time, only God. (P9)

They could have treated me much better. I think they saw I was young and thought I was pretending and they did not consider my pain. (P10)

At the time the doctor was sewing she said that I was weak, that I was not holding on and that I was already the second one that she saw like that. I was silent because if I said anything she would do even worse. (P8)

The strategy of being silent in face of pain not to suffer is extremely frequent and performed as a solution to avoid maltreatment, in the perspective that the woman who collaborates and does not make a scandal will be better served.22 In light of these considerations, many women already arrive at maternity homes with the idea that if they make a scandal they will be repudiated, as it is observed in the reports:

I stayed crying, only, because people say that when you make a scandal they let you suffer more. Then I was there on my own, walking, crying low. I did not make a scandal. (P1)

I stayed quiet. They told me that if I made a scandal they were going to let me suffer there. (P2)

These dialogues evidence that there is a strong culture disseminated among parturients that it is not allowed to show any type of alteration in their behavior during labor, especially if this change is related to screams or loud crying. This type of violence has been widely disseminated to these women through some professionals and family members who have already experienced it at the time of childbirth or who have already observed and been frightened by these acts of violence in maternity wards.

Other research 12 showed that some women reported hearing professionals say sentences like “if you scream it will hurt your baby; your baby will be born deaf” or “if you scream I stop now what I am doing, I will not serve you”.

Corroborating these considerations, health professionals’ disregard for the interviews in this study was reported by 9 (22%) of the puerperal women, as seen in the following speeches:

It looked like he was putting a calf out. I was not well treated, no. (P20)

Then they kept saying it is going to be normal until they said that I was going to be a cesarean section. […] Then, my father came and made a scandal because when they tried to hear the baby’s heart, they could not anymore. (P21)

The baby was already going out and I had to walk to the delivery room. So, I had my baby on the floor, I was laying there looking like a dog. I could even get an infection. (P22)

They tried, they tried and the boy did not come out. His heart was almost stopping and they said they could not explain why he was not coming out. Then, when I went to cesarean, they found that the boy was crossed. (P23)

I had my baby alone. I felt a lot of pain. I sat in a chair until he came into the world without any assistance. Alone! (P24)

They only did the cesarian section because the baby pooped inside. (P4)

These reports show that women are submitted to a hegemonic hospital power, assisted in subhuman situations not only by the lack of structure but also by the lack of decent assistance.23 In this perspective, neglect is characterized as a type of psychological aggression, consisting of a verbal or behavioral action that provokes feelings of inferiority, vulnerability, abandonment, emotional instability, fear, acuity, insecurity, alienation, loss of integrity, dignity and prestige, such as threats, lies, mockery, jokes, emotional pressure, humiliations, rudeness, blackmail and offenses.11

Faced with abandonment, parturients’ risks of complications during childbirth and postpartum increase dramatically. A research evidenced that care in hospitals is represented by neglect, abandonment and pain, and that these are linked to both psychological and physical violence.17

Another type of violence has been highlighted as being of a sexual nature, which...
is conceptualized as any action imposed on women that violates their intimacy or modesty, affecting their sense of sexual and reproductive integrity, and it may or may not have access to sexual organs and intimate parts of their body. Among them, there is the episiotomy; harassment; invasive, constant or aggressive digital vaginal examinations; enema; cesarean section without informed consent; rupture or detachment of membranes without informed consent; and the imposition of the supine position to give birth.11

The interviewees mentioned that in relation to this type of violence, 8 (20%) women were submitted to intrusive, constant or aggressive digital vaginal examinations; 5 (12%) to the use of episiotomy and 3 (7%) to the use of the forceps, both without informed consent. According to the Manual on Best Practices for Labor and Delivery, repeated or frequent vaginal exams, especially if performed by more than one person, as well as episiotomy, fall under category D of the recommendations, which is a practice often used improperly and that should be discouraged.4

Repeated abusive digital vaginal examinations are performed during a birth to check for cervical dilatation. A commonly used maneuver during touch examination is “dilation” or “manual reduction of the cervix,” emerging as a painful procedure performed to accelerate labor. It may be detrimental to the dynamics of childbirth and most of the time it is performed without the patient’s clarification or consent.11 The lack of clarification about the procedures and the pain caused during the procedure were also evidenced in speeches:

As this is my first son, I did not know what the vaginal examination was like, if it was just with the finger; only she did not do it with her finger, she placed her hand halfway down the wrist, then I cried, I closed my legs because I could not stand the pain. (P11)

They did the vaginal examination many times and it hurt. (P12)

They did vaginal examinations all the time, and I did not know why. (P13)

In this context, a Cochrane study aimed to ascertain the efficacy and the consequence of this examination found no research supporting or rejecting the use of routine digital vaginal examinations to improve the labor of women. The widespread use of such an examination is surprising, since there is no study that proves its effectiveness, in addition to the embarrassment it causes to parturients.24

Regarding episiotomy, none of the women interviewed related this procedure to a form of obstetric violence. The fact was only reported after specific question in the data collection instrument.

This practice has been incorporated into childbirth care since the beginning of the last century with the aim of reducing perineal lacerations, reducing the risk of subsequent urinary and fecal incontinence, and protecting the newborn from possible traumas at birth. Episiotomy, from the beginning, was used without any research to assess its risks. However, it is extremely important to highlight the possible immediate complications, such as blood loss, need for suturing and perineal pain; and after childbirth, intestinal, urinary and sexual dysfunctions, which lead to the conclusion that the reduction of this procedure is a priority for women’s health and for the professionals who serve them.25

Another type of obstetric violence is institutional aggression, which converges to hinder, delay or prevent women’s access to their constitutional rights, whether these actions or services are public or private. For example, the impediment of access to health care services and omission or violation of the rights of women during their gestation, childbirth and puerperal period can be mentioned.

In this context, based on some of the interviewees’ statements, the deprivation of the companion has still happened in some services, thus contravening Law 11.108/200526, which guarantees parturients the right to the presence of companions during labor, childbirth and immediate postpartum, under the Brazilian Health System:

I did not have a companion during birth because the doctor did not allow. He said they had no clothes and that my husband could not enter. I said there was a law but he said he could not. [...] My husband was dreaming of being there at that time, the first moment. I missed him a lot, because in the cesarean section the person gets very apprehensive, takes anesthesia and is alone, without anyone beside. (P18)

They said I could not have a companion and that is it. I wanted to, but I let it go. (P19)

The presence of the companion during childbirth and birth is effective in reducing feelings of pain and abandonment at these times. The presence of the family member or friend brings comfort and tranquility to the parturients.27 It is important to stress that the choice of the person who will be with this
woman must be made by her and the institutions should support it.

On the other hand, a study showed some resistance from the team regarding the presence of the companion, since many professionals see that this is just a mere spectator, even disrupting the work of the team for not understanding the dynamics of labor or some measures that should be taken to improve care for women.28

The forms of material and media violence were not explained by the puerperal women; however, addressing its conceptual aspects favors the knowledge and dissemination thereof. Material violence consists of active and passive actions and conduct for the purpose of obtaining financial resources from women in reproductive processes, violating their rights already guaranteed by law, for the benefit of individuals or legal entities, such as improper collections by health plans and professionals, induction to contracting healthcare plan in the private modality, under the argument of being the only alternative that makes the presence of the companion viable. Whereas media violence includes actions practiced by professionals through the media, aimed at psychologically violating women in reproductive processes, as well as denigrating their rights through messages, images or other signs publicly disseminated; apology to scientifically contraindicated practices for social, economic or domination purposes. Apology to cesarean surgery for banal reasons and without scientific indication, ridiculing normal birth and incentive to early weaning are examples that can be mentioned.11

Thus, due to the large number of unnecessary procedures and lack of humanized care in maternity wards, obstetric violence must be denounced by women victims of such neglect and disrespect, mainly because it involves a unique moment in which women should be protagonists of this process.

◆ Repercussions of obstetric violence on women’s lives and the main professionals involved

Health professionals are those who should be better prepared to give more support in humanized care to women during labor, delivery and postpartum. Unfortunately, in today’s obstetric reality, behaviors that differ from this targeted care are still present, especially in the public sectors.

The analysis of the reports of puerperal women showed that the aforementioned forms of violence cause damage that will affect women’s lives throughout their obstetric histories. Such damages can be observed in the following reports:

Never again in my life do I want to have a child in a public hospital. (P3)

I think that in another pregnancy I will be mistreated again. Go through it all again. (P5)

It changed my life. I did not feel well there, when I remember I feel afraid of going to the maternity hospital again. (P11)

I remember I could not do anything, God supported me and I am here telling what happened. (P15)

It affected me because nobody should be treated like that. If I was rich she would not have treated me like that. She recognizes a poor person. (P29)

The model of obstetric care that is not based on scientific evidence does not respect women’s rights and is fed by an extremely flawed method of health training and without due monitoring.22 The emotional traumas caused will remain forever marked in the memory of the victims and the idea of suffering linked to giving birth will continue to pass from generation to generation.

Studies already carried out show that women victims of violence have feelings such as fear and sadness.29 The speeches confirm these data, as evidence of the devastating feelings that are occasioned in the lives of the victims of obstetric violence.

Changes must be made in the form of serving parturients and such changes should sensitize the professionals from the moment of undergraduate course. Initiatives of the Ministry of Health, such as the preparation of technical manuals and other educational materials for professionals working on gestation and delivery, although relevant, have proved insufficient to reverse Brazil’s obstetric care model. Thus, not only physicians, but also the nursing team, treat the parturients with crude and overly authoritarian discourses. Interestingly, most of these professionals are female who have already experienced normal delivery, but this fact does not lead them to be more sympathetic and to have a more understanding behavior in relation to women’s experience,13 as observed in the following speeches:

After the nurse had taken her, there was no one else inside the room, the doctor wrapped his hand in gauze and stuffed it into me. He did not say anything to explain why he was doing that. I went to find out if this was correct and I did not find anywhere saying that this was correct. It was horrible. (P4)

I was feeling much pain and I held on to the nurse’s clothes and she said in a rough way: “do not touch me, you will get me dirty”.

P29
Then she left me alone in the middle of the hall to walk. (P27)

And she (the doctor) was screaming all the time and she said: ‘leave her there, she is faking’. I did not like. Then they took me to the delivery room and I could not walk anymore. She even called me a cry-baby. (P22)

When I got into the operating room, they kept saying they were about to leave and I arrived there. They kept complaining; it was a nurse. (P23)

They (the professionals) only told the person to be calm, and said that they could do nothing. (P25)

Health professionals are extremely important in the process of humanizing birth and delivery and in providing comprehensive care. The training of obstetrician physicians, however, has not been successful in making these professionals capable of providing quality and humanized care, since they are trained to use interventionist practices. On the other hand, the training of obstetrical nurses aims at a more humanized care focused on the physiology of childbirth.30

Professionals involved in the delivery have the opportunity to put their theoretical and practical knowledge at the service of the well-being of the woman and the baby. They can minimize cravings, pain, stand by, provide support, clarify, guide, help and assist in giving birth and being born. It is important to remember their responsibility in a process involving multiple births: the birth of a baby, a mother, a father, a new family.7

Despite the abovementioned reports of maltreatment perpetrated by professionals, in some of these other professionals intervened to prevent some acts of violence.

Then, another doctor came and she was very good and she said: do you want to kill the baby? Aren’t you seeing that it cannot be a normal delivery? (P28)

[…] and the doctor who entered said no, that I had no opening to have a normal delivery. (P30)

The health team can guide women in recognizing obstetric violence and in how to deal with it, in addition to referring them to some kind of follow-up or space, when necessary.

Thus, access to comprehensive and humanized care can drastically reduce the negative repercussions caused by experiences marked by pain, disregard and shame. The birth event is a particular moment that should not leave marks nor bad memories for the parturients. In addition, maternity wards should be welcoming places.

CONCLUSION

This research enabled a deeper perception about the main types of violence experienced by women served in some public services, as well as contributed with knowledge about the repercussions of this violence on the lives of women interviewed and the identification of the main professionals involved. Pain, repetitive and abusive examinations, maneuvers without scientific evidence of any benefit and neglect are the main forms of obstetric violence suffered by women interviewed. Physicians and nurses are cited as professionals involved, and trauma is portrayed as the main consequence in these women’s lives.

The present study allowed the visualization of the frequency of obstetric violence in public healthcare and the importance of providing a decent assistance at the time of delivery and after it. Care must be provided in a humanized way, respecting the woman as protagonist and minimizing physical, psychological, sexual and all other damages. However, the number of researches on the subject in the national scenario is still incipient and demands a greater involvement of students, professionals and researchers to deepen in this area, searching strategies to reformulate the obstetric scenario, combating obstetric violence and planning assistance for the consequences arising from this reality.

Finally, aspects related to the perception of puerperal women about obstetric violence, elucidated in the scope of this research, can be used as support for the health team, especially for the nursing team, with the aim of encouraging parturients to face childbirth as a unique experience that must be experienced by each woman, stimulating them to seek a re-signification of this moment from a perception that envisions a delivery.

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Corresponding Address
Camyla Felix Oliveira dos Santos
Rua Severino Nicolau de Melo, 225, Ap.310
Bairro Jardim Oceania
CEP:58037-700 – João Pessoa (PB), Brazil