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ORIGINAL ARTICLE

LABOR AND BIRTH IN THE RURAL REGION: OBSTETRIC VIOLENCE

PARTO E NASCIMENTO NA REGIÃO RURAL: A VIOLÊNCIA OBSTÉTRICA

PARTO Y NACIMIENTO EN LA REGIÓN RURAL: LA VIOLENCIA OBSTÉTRICA

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ABSTRACT

Objective: to investigate the forms of obstetric violence in childbirth and birth care. ***Method:*** a quantitative, exploratory, descriptive and cross - sectional study with 169 mothers in public maternity hospitals. Data were collected through a questionnaire and analysis by Microsoft Office Excel®-2013 Software. Subsequently, the information was organized into a database and presented in tables. ***Results:*** when evaluating forms of obstetric violence, unfair care and verbal abuse, discrimination based on certain attributes (eg race), abandonment, neglect or refusal of care and detention in the services provided were identified. ***Conclusion:*** the Brazilian rural region investigated presented several types of obstetric violence, similar to the national data, requiring actions with a view to its elimination. ***Descriptors***: Obstetric Nursing; Nursing; Parturition; Physical Abuse; Exposure to Violence; Rural Health Services.

RESUMO

Objetivo: investigar as formas de violência obstétrica na assistência prestada ao parto e ao nascimento. ***Método***: estudo quantitativo, exploratório, descritivo e transversal realizado com 169 puérperas em maternidades públicas. Os dados foram coletados por meio de questionário e a análise pelo *Software Microsoft Office Excel*®-2013. Posteriormente, as informações foram organizadas em um banco de dados e apresentadas em tabelas. ***Resultados***: ao avaliar as formas de violência obstétrica, identificaram-se cuidado indigno e abuso verbal, discriminação baseada em certos atributos (por exemplo, raça), abandono, negligência ou recusa da assistência e detenção nos serviços prestados. ***Conclusão***: a região rural brasileira investigada apresentou variados tipos de violência obstétrica, semelhantes aos dados nacionais, requerendo ações com vistas à sua eliminação. ***Descritores***: Enfermagem Obstétrica; Enfermagem; Parto; Abuso Físico; Exposição à Violência; Serviços de Saúde Rural.

RESUMEN

Objetivo: investigar las formas de violencia obstétrica en la asistencia prestada al parto y al nacimiento. ***Método:*** estudio cuantitativo, exploratorio, descriptivo y transversal realizado con 169 puérperas en maternidades públicas. Los datos fueron recolectados por medio de un cuestionario y el análisis por el software Microsoft Office Excel®-2013. Posteriormente, las informaciones fueron organizadas en una base de datos y se presentaron en tablas. ***Resultados:*** al evaluar las formas de violencia obstétrica, se identificaron el cuidado indigno y el abuso verbal, la discriminación basada en ciertos atributos (por ejemplo, raza), abandono, negligencia o rechazo de la asistencia y detención en los servicios prestados. ***Conclusión:*** la región rural brasileña investigada presentó variados tipos de violencia obstétrica, semejantes a los datos nacionales, requiriendo acciones con miras a su eliminación. ***Descriptores***: Enfermería Obstétrica; Enfermería; Parto; Abuso Físico; Exposición a la Violencia; Servicios de Salud Rural.

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INTRODUCTION

It is understood that obstetric violence, recognized as a public health issue by the World Health Organization (WHO), 1 is a recent issue in academic research and public policy formulation, but not in the reality of many women. It is increasingly defined and visible in social activism, mediated by social networks (cyberativism), and supported by a strong legal basis with a view to overcoming it.

In Brazil, the term obstetric violence is used to describe the various forms of violence that occur in the care of pregnancy, childbirth, postpartum and abortion. It is understood by the appropriation of the body and the reproductive processes of women by health professionals who express themselves through dehumanizing relations, abuse of medicalization and pathologization of natural processes resulting in loss of autonomy and ability to freely decide on their body and sexuality and negatively impacting the quality of life of women.[2]

Inhumane attitudes towards childbirth care in both the private and public sectors are known to be frequent. A study of Brazilian women reported that about a quarter of them went through childbirth suffering some form of violence in care, which was also reported by about half of those who had an abortion.[2]

Several actions were implemented as a way to prevent this kind of violence in health practices. The Stork Network, a strategy of the Ministry of Health (MH), is one of them and aims to schedule a series of care to guarantee women the right to reproductive planning and attention to pregnancy, childbirth and the puerperium to ensure safe birth, the satisfactory development and quality of life of children up to two years of age and the reduction of maternal and infant mortality. Other strategies are the Humanization Policy for childbirth and birth care and childbirth units linked to the Unified Health System, examples of combating the different dimensions of violence in obstetric care.[3]

It is understood that maternal mortality in Brazil still needs to be reduced, especially in the country's rural regions.[3] Thus, research, such as this one, seeks to verify the characteristics of delivery care and birth in parturients treated in public maternity hospitals with a focus on obstetric violence, are necessary in order to serve as a basis for future evidence-based interventions aimed at impacting the promotion of an active and humanized delivery contributing to the improvement of the quality of life of the parturients and reducing the incidence of present morbidity and mortality in labor.

It is within this scope, in the health area, an opportunity to act as an educating agent that, in order to empower, needs to know its population and context. Identifying these characteristics is a way of indicating actions necessary for birth and birth to be anchored in the human rights of women who are cared for in the public health system.

OBJECTIVE

- Investigate forms of obstetric violence in childbirth and birth care.

METHOD

This is a study from the Scientific Initiation Project entitled "Characterization of the delivery and birth process in the Baturité Massif", linked to the University of International Integration of Afro-Brazilian Lusophony / UNILAB, of the quantitative, exploratory, descriptive type , cross-sectional and hospital-based. 169 puerpaeas were part of the investigation. The research was carried out in two reference maternity units for the Maciço de Baturité (CE), rural region of the Brazilian Northeast, in the year 2016.

The following eligibility criteria were used for the selection of the sample: puerperal women with hospital delivery having, as outcome, a live birth, regardless of weight or gestational age, with a minimum period of 12 hours postpartum and who signed the Free and Informed Consent Form. Women who were unable to respond to the interview at the time of data collection or who declined to participate were considered ineligible.

It is reported that the researchers made initial contact with the puerpera who was hospitalized in the maternity wards, in the joint accommodation or in the fourth prepartum, childbirth and puerperium (PCP), following due care with the participants and respecting their due rest post childbirth. Then the research project was presented and explained, clarifying any doubts that might arise. Subsequently, a questionnaire was applied containing questions related to the following points: socioeconomic data, obstetric data and information on childbirth.

Data tabulation and analysis were performed using Microsoft Office Excel®-2013 Software. Subsequently, the information was organized in a database and presented in tables and tables to differentiate the sample investigated by mean, frequency and percentage.

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The forms of obstetric violence were characterized by categories of disrespect and abuse, [2] to classify the findings corresponding to the rural reality of the Brazilian Northeast. These categories were elaborated from a proposal[4] that, through the report "Exploring evidence of lack of respect and abuse based on the ease of childbirth", synthesized the evidence and knowledge on the subject and, through literature reviews, interviews and discussions with specialists, developed a theoretical framework highlighting seven categories of disrespect and abuse in health institutions.

The following seven categories are shown: first category (physical abuse); second category (imposition of non-consensual interventions); third category (non-confidential or private care); fourth category (undue care and verbal abuse); fifth category (discrimination based on certain attributes); category (abandonment, neglect or refusal of assistance); seventh category (detention in services).

The study was approved by the Ethics Committee in Research under the Certificate of Presentation for Ethical Appreciation (CAAE) - 49343315.8.0000.5576.

RESULTS

It is pointed out that the characteristics and the socioeconomic profile of the interviewees showed that women with a mean age of 25.4 years (± 8.5) participated in the study. The average monthly personal income was R $ 205.36, while the family income was around R $ 921.91 on average. There were 83 (49.1%) puerperae who reported being primiparous and 86 (50.8%), multiparous.

Table 1. Distribution of puerperae according to socioeconomic profile. Massif de Baturité (CE), Brazil, 2017.

Variables		n	%
Level of schooling	Illiterate	1	0.5
	Elementary school	75	44.3
	Highschool	84	49.7
	Higher education	9	5.3
Color	White	18	10.6
	Black	3	1.7
	Brown/Tanned/Mulata	144	85.2
	Yellow/Oriental	3	1.7
Marital status	Single	73	43.2
	Married/Stable union	96	56.8
	Widow	0	0.0
Paid activity	Yes	61	36.0
	No	108	63.9
Total		169	100

It is added that, with respect to the decision on the type of delivery, 126 (74.5%) of the 169 women interviewed claimed that they preferred to have a normal birth in early pregnancy. Another 30 (17.7%) reported the preference for cesarean delivery and 11 (6.5%) reported having no preference whatsoever about their type of delivery.

It is described, in relation to the factors influencing the decision on the type of delivery in early pregnancy, that 24 (14.2%) puerperae reported being due to the birth histories of family members and friends; five (2.9%), due to the husband's preference for the type of delivery; 24 (14.2%) reported being afraid of normal birth; six (3.5%), because of fear of normal delivery alter the vaginal canal; 18 (10.6%) reported that they wanted to ligate the tubes; 28 (16.5%) reported being afraid of cesarean section; 16 (9.4%) reported being afraid of anesthesia; four (2.3%) reported wanting to schedule the date of delivery; two (1.1%) because they wanted to have a known professional during childbirth; 22 (13.0%) reported previous positive experience with normal delivery; one (0.5%), previous negative experience with normal delivery; 12 (7.1%) women reported that they sought information on the Internet regarding types of births; three (1.7%) sought information in newspapers and magazines on the subject; ten (5.9%) watched television on childbirth; 66 (39.0%) mothers who reported that they decided on which type of delivery they would have because of normal delivery would be better than the cesarean section; 109 (64.5%) reported that in normal delivery there is a better recovery and nine (5.3%) mothers did not know how to inform the influencing factor on the type of delivery.

Furthermore, in the final period of pregnancy, close to the probable date of delivery, 83 (49.1%) women reported that they had already decided on normal delivery, while another 47 (27.8%) claimed that to be performed would be the cesarean and 39

(23.0%) did not yet know which type of delivery they would perform. Of these, 75 (44.3%) reported that decisions on the type of delivery were made by themselves, while 53 (31.3%) stated that decisions on the type of delivery were made by physicians, another three (1,7%), by nurses and 19 (11.2%) puerperas claimed to have been a joint decision between them and the doctor.

It was observed that 57 (33.7%) of the 169 postpartum women interviewed did not go into labor, while 112 (66.2%) reported having entered labor. Table 2 refers to the characteristics of this labor, regardless of the outcome in a normal or cesarean birth.

Table 2. Distribution of puerperal women according to labor data. Massif de Baturité (CE), Brazil, 2017.

Variables		Normal birth	%	Cesearean	%
Fluids / foods were offered during Labor		14	8.2	16	9.4
Parturients requested fluid / food during Labor		20	11.8	5	2.9
Administered intravenous serum during labor		34	20.1	30	17.7
Administered oxytocin		29	17.1	16	9.4
Administered via vaginal medication to induce / accelerate labor		4	2.3	1	0.5
Membrane rupture in the maternity ward		22	13.0	10	5.9
Got out of bed / wandered during labor		45	26. 6	34	20.1
Use of MNF for pain relief during labor	Shower	21	12.4	20	11.8
	Ball	2	1.1	3	1.7
	Massage	2	1.1	0	0
	Bench for squatting position	1	0.5	1	0.5
	Pony	10	5.2	18	10.6
Total			100		100

It was found that the mean time in which the women had their deliveries was 38.2 (± 5.5) weeks. Among the 169 puerperal women, 137 (81.0%) reported that the professionals who performed the delivery were not the same as those who underwent prenatal care, while 32 (18.9%) reported that the professional who gave birth was the same who did the prenatal.

Table 3. Distribution of puerperae according to data about the companion. Massif de Baturité (CE), Brazil, 2017.

Variables		n	%
Companion during hospitalization	Yes	158	93.4
	No	10	5.9
Type of companion	Companion/childs father	3	1.7
	Friend	20	11.8
	Mother	52	30.7
	Sister	32	18.9
	Aunt	7	4.1
	Sister in-law	20	11.8
	Cousin/Niece	12	7.1
	Mother in-law/Grandmother	12	7.1
	Nurse	1	0.5
Companions of choice of parturient	Yes	131	77.5
	No	29	17.1
Total		169	100

Among the information described by the puerperae, the position adopted during delivery was 134 (79.2%) in the supine position, one (0.5%) in the lateral decubitus, one (0.5%), of squatting and one (0.5%) in vertical position. It was also found that 54 (31.9%) women presented Kristeller's maneuver.

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Table 4. Distribution of puerperal according to delivery information. Massif de Baturité (CE), Brazil, 2017.

Variables		N	%
Type of birth	Normal	65	38.4
	With Forceps	1	0.5
	Cesearean	103	60.9
Professional who performed the birth	Doctor	99	58.5
	Nurse	45	26.6
	Doctor and nurse	4	2.3
	Midwife	3	1.7
	Health professional did not introduce themselves	2	1.1
	Could not inform	16	9.4
Knowledge of how the perineum was after delivery	Did not lacerate	29	17.1
	Lacerated but did not suture	2	1.1
	Lacerated and sutured	19	11.2
	Did episiotomy and raffia	9	5.3
	Sutured, do not know if lacerated / episiotom	3	1.7
	Could not inform	3	1.7
Applied epidural or spinal anesthesia in the labor or childbirth	No	48	28.4
	Yes, in labor	5	2.9
	Yes, in birth	35	20.7
	Could not inform	22	13.0
Position of baby at delivery	Cephalic	105	62.1
	Pelvic	8	4.7
	Cross sectional	3	1.7
	Could not inform	46	27.2
Total		169	100

It was also concluded that 31 (18.3%) of the 103 women who had a cesarean delivery as the outcome reported that in the prenatal period, it was decided that the delivery route would be the cesarean delivery, 14 (8 , 2%) said that during admission as a pregnant woman, 28 (16.5%) claimed that it was decided during admission as a parturient, 28 (16.5%) reported that it was decided by cesarean section in preterm delivery, six 3.5%), in the delivery room and one (0.5%) did not know how to report.

Each procedure was motivated as follows: two (1.1%) reported having a cesarean section; 12 (7.1%) wanted tubal ligation; four (2.3%) reported that the motif was circular in the cord; 18 (10.6%) by iterativity; five (2.9%) reported pelvic presentation of the baby; six (3.5%), position of the transverse baby; 38 (22.4%) reported that they did not have sufficient dilatation for the passage of the baby; four (2.3%) had oligodramnia; four (2.3%) reported fetal distress; 17 (10.0%) reported post-maturity; five (2.9%) by aminorhexe; seven (4.1%) reported having hypertension during labor; two (1.1%) had bleeding and two (1.1%) had diabetes. The data regarding the companion at the time of delivery are described in table 3.

Table 5. Distribution of obstetric violence practices identified according to categories of abuse and disrespect. Massif de Baturité (CE), Brazil, 2017.

Disrespect and abuse categories	Variables	N	%
Category 1 Physical abuse	Episiotomy	9	5.3
	Cesearean	103	60.9
	Touching during Labor	25	14.8
	Average of touching	2.2	
Category 2 Interventions not consented to / accepted on the basis of partial information	C-section due to circular cord	3	1.7
	C-section due to post maturity	17	10.0
	C-section to get a tincture	12	7.1
Category 3 Non-confidential / non-private care	Absence of private room	25	14.8
	Absence of a companio (Labor, birth, puerperium)	11	6.5

Using the categories of disrespect and abuse2 that classify the findings corresponding

to the rural reality of the Brazilian Northeast, the category 4 (unworthy care and verbal abuse) was not identified through the women's speech; category 5 (discrimination based on certain attributes - for example, race); category 6 (abandonment, neglect or refusal of assistance) and, finally, category 7 (detention in the services).

DISCUSSION

Through this study, the interface of obstetric care provided for childbirth and birth in public maternity hospitals of Maciço de Baturité, Northeast Brazil, is investigated to investigate the forms of obstetric violence that are frequent in maternity wards, in view of the Good practices recommended by WHO.

Obstetric violence is considered a new field of study in Brazil and in the world, but it has always been present becoming a problem for society and causing a governmental mobilization to encourage good practices at the time of childbirth.1 Acts of violence against women at the time of prepartum, childbirth, and puerperium are commonly performed in Brazilian maternity hospitals and users are accustomed to these practices.[4]

Academic interest in the topic of obstetric violence in recent years is broadened, and scientific production includes research on the training of professionals and population-based data, such as the Brazilian research on obstetric violence and quaternary prevention, 2 which has contributed unprecedentedly, for the visibility of this type of violence. According to the current scenario of childbirth care in Brazil, it was necessary to publish Law No. 12,401, of April 28, 2011, so that technologies, medicines, products and procedures at the time of birth and birth were reviewed establishing a Clinical Protocol and Therapeutic Guidelines based on scientific evidence to confirm the efficacy, safety, effectiveness and costing of the interventions.[5]

It is noticed that the profile of the parturient presented in this study resembles the Brazilian profile obtained through the research "Born in Brazil" in which 23,940 women were interviewed. In the abovementioned study, the profile of the parturients was constituted by: average age of 25.6 years; 64.7% declared themselves to be brown or black; about 40% worked with pay and 46.9% were primiparous.[6]

It was found that preferences at the beginning of gestation of the Brazilian women interviewed in the aforementioned study revealed, in 66% of the interviews, that they preferred normal delivery; 27.6% reported preferring cesarean delivery and 6.1% did not know their preference. But it is known that these percentages tend to change throughout the gestation and are totally dependent on the social ties of the pregnant woman.[6]

Two of the factors that influenced the choice of the type of delivery by the woman were cited as the main ones in this research: the fear of normal birth - mostly associated with fear of pain - and the report of family members and friends about the experience of childbirth. Nevertheless, in a study carried out in Mato Grosso do Sul, with 25 parturients, the authors affirm that, in most cases, behind the woman's desire for cesarean section, there are three pillars of support: fear, convenience and misinformation. The woman's own previous obstetric experiences decisively influence the time of her choice. For this reason, efforts should be invested to improve care for normal birth, since it is desired to reduce the number of cesareans without real indications and, if the delivery has a quality assistance, it is evidenced that the woman again opts for it.[7]

Among other factors influencing the influences, the meanings that women attribute to the types of delivery and the advantages and disadvantages conferred on them are detected. The main advantage given by women to vaginal delivery is the rapid recovery to return to the chores of their daily lives. And the most cited disadvantage is the fear of the pains and complications and even the death of the baby. In contrast, the most obvious advantages of cesarean delivery are revealed: avoiding the fear of pain and saving the baby's life. And the disadvantages: Postpartum pain and the risks inherent in surgery.[8]

These influences are reflected directly in the final choice of the type of delivery that will be performed. In a study conducted in Mato Grosso do Sul, 56% of deliveries were cesarean sections.7 In the present study, this number was 60.9%, which exceeds the number sought by the Ministry of Health and WHO.

It is recalled that the kind of birth performed almost exclusively until the nineteenth century was natural childbirth, also known as normal or vaginal birth, in which, among primitive peoples, the woman quickly recovered and returned to her normal routine. However, in today's society, normal childbirth is incurred by the feeling of pain, which generates fear and anxiety.[9]

It is known that cesarean delivery, in turn, arose for the purpose of saving the life of the fetus and / or the mother. With the

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technological and scientific evolution, it came to be considered the safest form of birth, but, over time, it assumed other possibilities such as: to avoid the intrinsic pains when giving birth and, from this, to diminish, on the one hand, the anxiety and fear.8 For these and other reasons, in some countries, such as Brazil, the percentage of cesareans exceeds that of normal deliveries.[10]

Data is shown where Brazil has a high rate of cesarean sections both in the public and in the private network.[3] According to the World Health Organization, Brazil is a concern for the high rates of cesarean surgeries, which causes fetal and fetal prematurity increase in maternal morbidity and mortality.[11] According to the National Supplementary Health Agency (NHA), cesarean rates in the country's accredited network were 84.6%.[10] According to the Ministry of Health, the preliminary data for the year 2015 show that, in the Unified Health System, 424,065 cesareans were performed only in the Northeast and 1,697,954 in Brazil.[12]

In terms of the final decision by the type of delivery, still largely or influenced by the doctor, this part of the results of the research "Born in Brazil": at the end of gestation, there was already the decision to have a cesarean section in one third of women and, for a quarter, there was still no decision as to the type of delivery; 51.5% of the women presented a cesarean section as the final delivery method, and 65.7% of them did not start labor. The highest proportions of cesarean sections were observed in pregnant women with some intercurrence during pregnancy (71.9% vs. 32.9%). The data from this study show that in 17.7% of the deliveries performed at the institutions, there was the decision of cesarean delivery in prenatal care and 16.7% at the time of maternity admission. One study showed that one-fifth of all women presented a source of private pay for childbirth care seeking better care, which demonstrates a significant change in the initial planning of women who become vulnerable to the institutionalization and medicalization of childbirth.[6]

One of the most veiled types of violence is water restriction, but it is known that the intake of fluids during the active phase of labor is already being indicated. As an example, in a study carried out in Spain, 33% of women ingested fluids during the active period of labor without any complications.[13]

It should be noted that, according to the American College of Obstetricians and Gynecologists, in 2017, for most women in labor, a specific position should not be determined for the prepartum and delivery period, also showing that the interventions in women of normal risk should be minimally invasive and the use of non-pharmacological methods for pain relief.[14]

is evidenced, through the findings of this study, that in 26.6% of the interviewed women, synthetic oxytocin was administered, the lithotomy position was the most used during normal delivery and the vertical position was adopted by only 0.5% of pregnant women. It was observed that non-pharmacological methods for pain relief were not offered to pregnant women in labor, with a quantitative of 20.3%.

It is recommended, according to the Guidelines for Normal Birth, that the choice of the delivery position should be made by the woman.[5] In a study on humanized delivery, only 48% of women chose the delivery position, but this number is still negligible , considering the autonomy of the woman.[15] In the study presented here, the largest portion of deliveries occurred in the dorsal decubitus, which again demonstrates a failure in care, since, according to the Ministry of Health, the recommendation of vertical positions during labor assists in the descent of the baby and consequent progression of labor. It is notorious, in this sense, that there is a lack of orientation and clarification of these women.[16]

It is clear that, with the valorization of humanized delivery, there was an increase in the rates of use of non-pharmacological methods for pain relief. In this study, the method most used by the parturients was the horse (22.4% - 38/169). In a study carried out in a public hospital in Fortaleza, the horse was exclusively used by 33.3% of parturients (17/51) and associated with the Swiss ball in 11.7% of labor (6/51). The same consists of a seat with a place that allows the support for the arms in which the woman takes the seated posture with the back leaning forward. His method of relief is based on the pelvic balance that is provided.[16] The second favorite method was the sprinkler bath (11.8% - 20/169). In an experimental, randomized, blinded clinical study in São Paulo, it was found that the hot bath associated with exercise therapy with the ball brought a significant decrease in the pain score (p-value = 0.0150).[17] In the search for a smaller number of interventions, the team of professionals in the obstetric area has played a relevant role in the implementation of these types of care.

It is identified that, besides the use of non-pharmacological methods for pain relief,

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there is another important factor for the care with the psychological aspect of the woman, which is the presence of the companion during the hospitalization. In this study, this index was 93.4%, which surpasses the country-level statistics established by a study conducted by the "Nascer no Brasil" survey in which the percentage was 75.5%.[6] However, while the data of the aforementioned research indicate the father of the child as the most frequent companion and the mother of the puerperal as the second most chosen, in the Maciço de Baturité, the mothers of the women were the most requested, followed by the sisters of the puerperal, and the companions occupied the ninth place , which reflects the cultural aspects of this region.

Through the role of the companion, the patient is given calm and tranquility, reducing the traumatic experiences associated with the time of labor and delivery18. However, research developed in Santa Catarina revealed that there is still much to be built so that there is respect for the law that guarantees the presence of the companion in this scenario since the professionals consider that the surgical room and vaginal delivery is not a place for companions and that the same can not enter because it is not emotionally and psychologically prepared for the moment. In many cases, the companion must require to enter.[19]

The use of oxytocin has gradually been reduced to accelerate the process of labor, since, at present, labor is recommended with the minimum of interventions. A study carried out in Minas Gerais showed that this reduction, even if small, has happened. There are studies that relate the performance of obstetric nurses in childbirth to a lower rate of interventions.[20]

Of particular note is the Kristeller Maneuver. On it, there is no evidence to prove its beneficial utility. What is known is that this pressure exerted on the abdomen of the parturient can be dangerous for the uterus and generate traumas in other internal organs, as well as it can bring damages to the baby's safety, which makes this practice not recommended for its risks occupy a significant scale in the face of its benefits.[21] It is characterized as a position of great passivity in relation to hospital authority.

Attention is given to another practice that is episiotomy. Currently, it is used in a restrictive, non-routine manner, since there are studies that prove that its accomplishment can have undesirable effects, such as the negative influence on pleasure during sexual intercourse, greater trauma in the perineal region and longer recovery time, among other psychological damages that can be observed. It falls into category D of practices that are often used inappropriately. [22]

It is perceived that, although evidence suggests that experiences of disrespect and mistreatment of women during childbirth care are widely disseminated, [2-4,23-4] currently, there is no international consensus on how these problems can be scientifically defined and measured.[1]

An act of physical or verbal offense against pregnant women during pregnancy, labor, postpartum or abortion is conceptualized through the World Health Organization.[1]

It was characterized the obstetric violence in this study through the impossibility of entering the institution, imposing difficulties in attendance, verbal abuses by professionals, lack of preparation in the physical structure, an impediment to the patient's choice of companion, and unnecessary procedures such as the tricotomy, the Kristeller maneuver and the synthetic oxytocin, [2] which are present in the maternities of rural areas of Northeast Brazil.

Disrespect and abuse during childbirth were reported in health facilities that included physical violence, deep humiliation and verbal abuse, coercive or non-consensual medical procedures (including sterilization), lack of confidentiality, lack of informed consent before refusal to administer painkillers, serious breaches of privacy, denial of hospital stay, negligent care during childbirth, leading to preventable complications and life-threatening situations, and detention of women and their newborns in institutions after childbirth due to inability to pay. Among others, adolescents, single women, low socioeconomic, ethnic minority, migrant and HIV positive women are particularly likely to experience abuse, disrespect and ill-treatment.[23-4]

It was found in the survey "Obstetric Violence: Offense to Human Dignity", that of the 326 women, 86 reported having suffered some form of violence. The study also showed that the nurse is considered one of the perpetrators of verbal aggression to the parturients.[9] The data of this study show that the professional who stood out in the delivery assistance was the doctor, performing 58.5% of the procedures.

Classifications of obstetric violence are proposed by some authors.[1-2] In this study, we chose to use the categories of disrespect and abuse in the study "Obstetric violence and quaternary prevention: what is and what to

do" [2] to classify the findings corresponding to the rural reality of the Brazilian Northeast. The author draws a parallel between the category of disrespect, the corresponding rights by category, and also exemplifies situations of obstetric violence.

Among the seven categories identified by the author, three could be found, according to the women's discourse, relating them to unnecessary episiotomies, cesarean deliveries and vaginal touches (Category 1); (Category 2) and non-custodial care (Category 3), which violates the right of women to care free of harm and ill-treatment and the right to information and privacy respectively.[2]

It is denounced that one in four Brazilians interviewed said they had suffered some violence at the time of delivery in both public sectors and private health sectors. The Northeast was the region with the most verbal obstetric violence, with 27%. 60.9% of procedures had an outcome in cesarean delivery and 39.0% in normal (vaginal) delivery. 93.0% had a companion during labor, 82.5% reported the presence of privacy at the time of delivery, and 39.0% of the pregnant women reported having used non-pharmacological methods for pain relief.[3]

In Venezuela, a study of 425 postpartum women showed that 70% of the cases of obstetric violence reported in the study were practiced by nurses, although there is an organic law in the country that criminalizes ill-treatment practices against pregnant women in health services.[4]

According to WHO, it is advised that in order to prevent and eliminate disrespect and abuse of women during institutional childbirth care throughout the world, the following measures should be taken: increased support from governments and social development partners for research and action against disrespect and ill-treatment; start, support and maintain programs designed to improve the quality of maternal health care, with a strong focus on respectful care as an essential component of quality of care; emphasize the rights of women to a dignified and respectful care throughout pregnancy and childbirth; produce data on practices that are respectful and disrespectful to health care, with systems of accountability and meaningful support to professionals; involve all stakeholders, including women, in efforts to improve the quality of care and eliminate disrespect and abusive practices.[1]

CONCLUSION

Through this study, the identification and categorization of the various forms of obstetric violence in the Brazilian rural region where cases of violations of women's rights to respect care, the right to life, health, discrimination, ie fundamental human rights, similar to national and international data, requiring action to eliminate it.

Obstetric violence has been shown to be a systemic and multifactorial public health problem with a major impact on maternal and child health. Measuring and understanding women's abuse and disrespect contributes to their elimination and prevention. The engagement of professionals involved in care is expected to be an agent that promotes women's rights by making use of human approaches focused on the needs of the mother-child binomial and anchored in strong scientific evidence.

The limitations of the study were related to the place and period of application of the questionnaire. The fact that the filling occurred during the immediate postpartum, while the puerperas were still in the institution, corroborated the exposure of more diverse emotions, whose period allowed for the potentiation of hormonal effects, adjusting to the new stage of life. In addition, there was the fear of criticizing the professionals who were in the same environment or until the exacerbation of this criticism through the feeling of nonconformity and the difficulty in reaching a more significant sample, since deliveries with some kind of intercurrence were referred to reference hospitals and were not included in the survey.

It was concluded that there was a specificity regarding the location of the study being in the rural area, showing that such data set the precedent for new research that seeks to evaluate the professionals' understanding and to identify other forms of obstetric violence that are often neglected. It is also recommended to discuss this issue in the policies of violence against women with the aim of promoting empowerment and understanding about the subject.

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