

ORIGINAL ARTICLE

OBSTETRIC VIOLENCE: EXPERIENCE OF A MULTIDISCIPLINARY HEALTH TEAM

VIOLÊNCIA OBSTÉTRICA: EXPERIÊNCIA DA EQUIPE MULTIDISCIPLINAR EM SAÚDE

VIOLENCIA OBSTÉTRICA: EXPERIENCIA DE UN EQUIPO MULTIDISCIPLINARIO DE SALUD

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ABSTRACT

Objective: To describe a multidisciplinary health team's understanding, experience, and propositions regarding obstetric violence. **Method:** A qualitative, descriptive study was carried out in a public maternity hospital in the countryside of São Paulo. Forty-three professionals from different categories were interviewed. Data collection was performed through semi-structured interviews. The data analysis was based on Bardin's Content Analysis framework. **Results:** From the transcribed speeches, the following categories emerged: 1 - Unfamiliarity with obstetric violence; 2 - Obstetric violence reports; 3 - Obstetric violence practices; 4 -Need for training on obstetric violence; 5 - Need for insertion of obstetric nurses; 6 - Need for physical restructuring and insertion of prepartum, delivery, and postpartum (PDP) rooms. **Conclusion:** Some participants demonstrated ignorance about the topic. The importance of the health team's knowledge about obstetric violence is highlighted to identify, intervene, and provide humanized care. Obstetric violence is favored by the lack of restructuring of the environment and materials, shortage of human resources, and work overload of professionals. It is considered opportune to promote training to help health professionals adopt evidence-based conducts.

Descriptors: Violence Against Women; Midwifery; Humanizing Delivery; Patient Care Team; Pregnancy.

RESUMO

Objetivo: Descrever a compreensão, a experiência e as proposições da equipe multidisciplinar em saúde em relação à violência obstétrica. **Método:** Estudo qualitativo, descritivo, desenvolvido em maternidade pública do interior paulista. Entrevistaram-se 43 participantes profissionais de diversas categorias. Coleta de dados realizada por meio de entrevista semiestruturada. Dados

analisados e fundamentados na Análise de Conteúdo de Bardin, modalidade temática. **Resultados:** Emergiram a partir das falas transcritas as categorias: 1 - Desconhecimento da violência obstétrica; 2 - Relato sobre violência obstétrica; 3 - Práticas de violência obstétrica; 4 - Necessidade de capacitações sobre violência obstétrica; 5 - Necessidade da inserção de enfermeiras obstetras; 6 - Necessidade de reestruturação física e inserção de quarto para Pré-parto, Parto e Pós-parto (PPP). **Conclusão:** Alguns participantes demonstraram desconhecimento sobre o tema. Ressalta-se a importância do conhecimento da equipe de saúde sobre a violência obstétrica, para que possam identificar, intervir e prestar assistência humanizada. A violência obstétrica é favorecida por falta de reestruturação do ambiente e de materiais, escassez de recursos humanos e sobrecarga de trabalho dos profissionais envolvidos. Considera-se oportuna a promoção de capacitações que aproximem os profissionais de saúde de condutas baseadas em evidências científicas. **Descritores:** Violência contra a mulher; Tocologia; Parto Humanizado; Equipe de Assistência ao Paciente; Gravidez.

RESUMEN

Objetivo: Describir el entendimiento, la experiencia y las propuestas de un equipo de salud multidisciplinario sobre la violencia obstétrica. **Método:** Se realizó un estudio descriptivo cualitativo en una maternidad pública del interior de São Paulo. Se entrevistó a 43 profesionales de diferentes categorías. La recolección de datos se realizó mediante entrevistas semiestructuradas. El análisis de datos se basó en el marco de análisis de contenido de Bardin. **Resultados:** De los discursos transcritos surgieron las siguientes categorías: 1 - Desconocimiento de la violencia obstétrica; 2 - Informes de violencia obstétrica; 3 - Prácticas de violencia obstétrica; 4 - Necesidad de formación sobre violencia obstétrica; 5 - Necesidad de inserción de enfermeras obstétricas; 6 - Necesidad de reestructuración física e inserción de salas de preparto, parto y posparto (PPP). **Conclusión:** Algunos participantes demostraron desconocimiento sobre el tema. Se destaca la importancia del conocimiento del equipo de salud sobre la violencia obstétrica, para que pueda identificar, intervenir y brindar atención humanizada. La violencia obstétrica se ve favorecida por la falta de reestructuración del entorno y materiales, escasez de recursos humanos y sobrecarga de trabajo de los profesionales. Se considera oportuno promover la formación para ayudar a los profesionales de salud a adoptar conductas basadas en evidencia. **Descriptor:** Violencia contra la Mujer; Partería; Parto Humanizado; Grupo de Atención al Paciente; Embarazo.

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INTRODUCTION

The term "obstetric violence", internationally used as disrespect and abuse or mistreatment during childbirth, was designed to reflect professional deficiencies in the healthcare of pregnant women. Obstetric violence is defined as the appropriation of bodily and reproductive processes by health professionals, expressed through dehumanized treatment, drug abuse, and approach to natural processes in the form of pathological events, corroborating the loss of autonomy and decision of women about their bodies and their sexuality, generating a negative impact on the quality of life of women.¹⁻²

The WHO intrapartum care guidelines recommend for all women, in the pregnancy-puerperal cycle, healthcare practices based on dignity, privacy, and confidentiality, ensuring freedom of choice and the necessary information, absence of harm and abuse, and continuous support during labor and childbirth.³

Improved quality and humanized access to health for women can reduce mother and child morbidity and mortality rates.^{1,4-5}

Therefore, respectful and dignified care are fundamental conditions for every pregnant woman, ensuring a positive motherhood. Still, mainly for cultural reasons, women's empowerment at birth is not common, and optimum healthcare is still not achieved in most healthcare settings.³

The experiences lived during motherhood directly affect women's health. There are records of situations of violence during childbirth in several countries, whether physical /sexual/verbal abuse, and discrimination. Young and low educated women are the most affected by obstetric violence, suggesting inequalities in how they are treated during childbirth.^{2,4-5}

A survey conducted in 2010, by the Perseu Abramo Foundation, showed that 25% of women who had normal births had gone through disrespectful situations and mistreatment during childbirth.⁶

The national survey "*Nascer no Brasil*" points to a care model marked by unnecessary and, in most cases, harmful interventions, exposing women and children to iatrogenic events. Oxytocin was administered to 40% of women, and 37% underwent the Kristeller maneuver. More than half of the women had an episiotomy, and most were approached in the lithotomy position during birth.⁷

Violence in childbirth is underrated by the power relations established by health professionals over the woman's body. Women end up accepting everything that is imposed, as they do not recognize violence and believe that the professional has all the knowledge about what should or should not be done during the birthing process.⁸

A study carried out in public and private hospitals in Brazil revealed that one in four women reported aggression during childbirth.⁹

Although obstetric violence is a contemporary theme, other studies reveal that the issue is still covered up, and that professionals who witness these situations hide and protect the aggressor for fear of conflicts and hostility.¹⁰⁻¹¹

Given the above, it is essential to unveil the healthcare team's understanding, experience, and propositions, since implementing a humanized care model for labor and birth is still a challenge for healthcare institutions and professionals. Furthermore, despite advances in the discussion on this theme, national research that reveals the understanding of the multidisciplinary team is still scarce.¹²

OBJECTIVE

To describe a multidisciplinary health team's understanding, experience, and propositions regarding obstetric violence.

METHOD

A descriptive, qualitative, and exploratory research was carried out. The chosen scenario was a public mother and child hospital, located in a Brazilian municipality in the countryside of São Paulo, serving 62 municipalities and providing pediatrics, gynecology, obstetrics, and clinical-surgical services, inpatient, and outpatient care. The hospital is also a reference for high-risk pregnancies and mother and child emergencies. Since 2002, the hospital has been part of the "*Amigo da Criança*" hospital initiative of the Ministry of Health of Brazil, which promotes actions with a focus on breastfeeding. Since 2017, the hospital has also become part of the Apice On project, an improvement and innovation project for care and teaching in obstetrics and neonatology.¹³⁻¹⁵

Professionals from the multidisciplinary health team participated in the research, including nursing assistants, nurses, physical therapists, speech therapists, assistant obstetric physicians, resident doctors, psychologists, social workers, and medicine and nursing undergraduate students. After agreeing to participate in the research and registering their consent by signing the Informed Consent Form, 43 participants were engaged.

Data were obtained through individual interviews, guided by a semi-structured script, created by the main researcher. The interviews were carried out from June to September 2018, in a private room in the hospital, without the presence of other people, and with the aid of a recorder to ensure the reliability of the collected material. The number of interviews carried out was established by saturation criterion. As this is a qualitative study, the researcher was not concerned with the quantification of the participants, but with the representativeness of the statements.

For data analysis, the Bardin content analysis technique was used, which includes a thematic modality consisting of a set of communication analysis techniques that aim to obtain indicators of knowledge regarding key message variables.¹⁶

The following steps were conducted in the qualitative analysis: categorization, inference, description, and interpretation. Such procedures do not occur sequentially. It is customary to a) decompose the material to be analyzed into parts; b) distribute the parts into categories; c) describe the categorization result (exposition of findings found in the analysis); d) make inferences from the results (using assumptions accepted by the researchers); and e) interpret results obtained based on the theoretical foundation adopted.¹⁶

The interviews were transcribed in full, respecting the colloquiality of the speeches. The testimonies were identified by letters to maintain the participants' anonymity, as follows: NA for nursing assistant, SW for social worker, N for nurse, S for student, PH for physiotherapist, ST for speech therapist, RPH for resident physician, O for obstetrician, P for psychologist, and OT for occupational therapist, followed by numbers such as N01, NA02, successively.

It is reinforced that the researcher respected the ethical and legal aspects of research involving human beings. The study was developed following the ethical precepts of Resolutions nº 466/2012 and nº 580/2018 of the Brazilian National Health Council.¹⁷ The research was approved by the Ethics and Research Committee of the *Faculdade de Medicina de Marília* - FAMEMA, by Certificate of Presentation for Ethical Appraisal nº 85417318.6.0000.5413, and opinion nº 2.585.111.

RESULTS

Ten categories of professionals were identified: 13 nursing assistants (30.23%), nine nurses (20.93%), six obstetrics/gynecology resident doctors (13.95%), four obstetricians (9.3%), two social workers (4.64%), two undergraduate nursing and medicine students (4.64%), two physical therapists

(4.64%), two psychologists (4.64%), two speech therapists (4, 64%), and one occupational therapist (2.32%). As for working time at the institution, 12 (27.9%) professionals have worked for one year or less and eight (18.6%) for more than ten years.

Thematic Categories

Based on the transcribed statements and the guiding questions implemented during the interviews, the thematic categories presented below were highlighted.

Category 1 - Unfamiliarity with obstetric violence

Some professionals were unaware of the term "obstetric violence". They questioned whether the term applied to hospitalization cases, pregnant women being at home, and even whether "obstetric violence" was related to abuse issues.

Obstetric violence [...] Can we jump to another subject? [...] Are you talking about violence cases affecting pregnant woman in hospitals or at home? [...] I really have no idea about what is this. (NA06, NA12, NA15, NA20, NA24, NA25)

Difficult huh? I don't think I've ever seen this happening. Is it some kind of abuse, in this case? I honestly have never seen anything that I judged to be violence. (NA32)

Category 2 - Obstetric violence reports

Other professionals have defined obstetric violence, defining the term as "conducts" that could be avoided and are practiced inappropriately, without a scientific basis. These include attitudes of abuse of power, decisions without the woman's consent, inappropriate verbalizations directed at her, and lack of guidance.

For me, obstetric violence is any act done with the woman in the prepartum, childbirth, or the postpartum period, which goes against the latest scientific evidence. I think anything that is done that is no longer proven, outdated, or has dubious effectiveness should be considered obstetric violence. (RPH33)

[...] Disrespectful comments, inconvenient laughs [...] it can come from the nursing team, the medical team, someone can tell her "why are you screaming now? you didn't scream when you were getting pregnant", "when you were getting pregnant, it didn't hurt" [...]. (N14)

Obstetric violence is everything that goes against women's rights. It's not just physical violence, it's also psychological violence, the way to treat pregnant and postpartum women and harm their rights as pregnant women. (N22)

[...] Fasting without indication, prolonged fasting, providing the patient IV fluids only, leaving the pregnant woman deprived in bed, unable to move without indication, forcing a

cesarean surgery without first trying the normal delivery, going straight to a cesarean surgery, forcing women to give birth in a certain position like supine, tying the patient's legs, not letting women choose the birth position or not allowing her to choose a physiological position [...] screaming at the woman, being disrespectful with the pregnant woman, humiliating the woman, not answering questions, not giving advice on procedures, performing several vaginal exams by different healthcare professionals. (PH38)

Some professionals reported not having witnessed practices consistent with obstetric violence in the workplace, with short, objective, and similar reports.

No, not so far. (NA03, OT04, NA06, P10, P11, NA12)

Category 3 - Obstetric violence practices

Most of the professionals interviewed have observed obstetric violence in their work environment, including approaching women in a standard position during labor, leg binding, Kristeller maneuver, episiotomy without indication, and tubal ligation without consent.

[...] Unfortunately, here there is a standard of care for normal birth, the woman is often forced to stay in a lithotomy position and is not free to choose the birth position, the legs are often tied, procedures are performed that are no longer considered current, such as Kristeller's maneuver... many times, I've seen it happen, it's a maneuver that is banned, you have more harm than good, it shouldn't be done anymore. Episiotomy is often done without indication, but many professionals think that there is that case of selective episiotomy (not routine), so I end up seeing many cases of episiotomy. Apart from some treatments with the woman that I have already witnessed. For example, I have seen some patients who had children from different fathers (two, three children, each one from a different father) being offended. I have seen the nurse assistant make fun of this [...] She used to said to adolescent patients, sometimes very young: "I'll see you again next year", "when you were having sex, it was good", "when you were having sex, you didn't wanted to be treated like a child". This is too sad. (RPH33)

[...] some maneuvers are unnecessarily performed during labor [...] some people unnecessarily keep the patient fasting, end up restricting the patient to the bed, or to a certain position, without directing the patient about moving or walking. Even maneuvers like pressing the woman's belly to get the baby born, performing episiotomy without indication, using oxytocin without indication, and not respecting the woman's desire regarding spontaneous vaginal delivery or cesarean surgery. We know that women must be instructed to be able to make decisions during childbirth, but this right is not always guaranteed. In addition to the aggressive attitudes and verbalizations, many professionals

are rude [...] some people throw all responsibility onto the woman instead of supporting her. For example, I have seen a woman getting vaginal exams repeatedly, even when she didn't want it. Then the professional said, "since that's the case, I won't examine you anymore, so now you're going to have the baby alone". Several behaviors are not adequate [...].(N35)

The speeches of undergraduate medicine and nursing students related to obstetric violence referred to the attitudes of professionals who performed the Kristeller maneuver during childbirth, and often performed tubal ligation without consent.

[...] Most of the cases of violence I have seen have happened during cesarean sections; there was also the use of Kristeller's maneuver, sterilization without consent; once, a nurse asked if the patient had had sterilization, and the doctor performing the cesarean said no, but she actually had had it done. In addition, many procedures are performed without the woman's consent. The woman wanted a vaginal birth. She was evolving towards it. It was her will. She had no justification for having a cesarean surgery, and they performed the cesarean section anyways. In a vaginal birth, they tie the woman's leg, and assistants impose "breathe this way, not your way", in short, the woman has to be the protagonist of the birth. They were taking away all her autonomy, forcing the childbirth to be done in a certain way, imposing absurd conducts rather than helping women. (S42)

Category 4 - Need for training on obstetric violence

Some professionals recognized the importance of training the health team in order to improve labor and delivery care and to update themselves, with a scientific basis, to change practices and behaviors.

The team needs training. The issue with doctors is very difficult; they want to impose many things. I think training is needed. I know it's difficult to convince them, but the team needs. Sometimes the team forget to treat women with dignity, because of the dynamics, the number of patients. It's just another patient, you know. (P01, OT04, ST27, N30)

[...] People should update themselves, a large part of obstetric violence happens because people do not update themselves. They think that normal birth is like a cake recipe, that every birth has to be the same, as they learned in college, so they end up replicating what they see the older ones doing [...]. My teachers and assistants are not up to date, and if we don't go after the information, we end up buying this. We end up replicating violence and not even think that it is violence. The assistance is very medicalized. Childbirth is very medicalized. The main issue is the lack of updates and information. (N13, RPH16, RPH33)

The entire team need to be informed [...] The team need support to be prepared. Our team is not prepared for an adequate delivery. The team that works with in this scenario today is the one that works in the OC [Obstetric Center], and no one has been specifically trained to work at the Obstetric Center. (N35)

Category 5 - Need for the insertion of obstetric nurses

Some professionals expressed in their speeches the need for trained obstetric nurses to assist women during labor, delivery, and postpartum, in addition to stressing the importance of this professional.

[...] There had to be an obstetric nurse for pre-partum, delivery, and postpartum. It is essential to have a nurse working just in this sector. An employee performing only this job doesn't have to divide his energies between different sectors, as it has been done currently. (N05, O18)

[...] A specialized professional is needed, who can perform all monitoring measures, who can be closer to the patients, and this professional is the obstetric nurse. The nursing team knows how to deal with monitoring, and they do it better than any professional, not just monitoring, but this thing of being close, of doing things in a humanized manner. [...] A trained professional would enhance the quality of the service. (O26)

Category 6 - Need for physical restructuring and insertion of prepartum, delivery, and postpartum (PDP) rooms

Improvements were suggested regarding the physical structure of the environment available for parturient women. The interviewees reported the existence of an improvised environment with a precarious physical structure, negatively interfering in the conduct of labor, which is not consistent with the humanization practices of labor and birth.

The physical structure is a very important issue. We need specific rooms for pre-delivery, delivery, and puerperium in the same center, so that the patient can have adequate physical space during labor. There are many options for this, from a suitable shower, bathtub, birthing ball... the patients should be assisted in a welcoming environment and choose the birth position they want. All of this is more favorable when pre-partum, delivery, and puerperium are all done in the same place. (O18)

The first issue is the structure. We do not have a structure suitable for normal birth. Our pre-delivery room is ridiculous. We have two pre-delivery beds with one bathroom, and the pre-delivery room is poorly located. People go through the room, many times. The room is in front of the surgical center and a staircase, access to it is very bad. It should have to be located in a more appropriate place. It should have more pre-delivery beds, so

that we could manage the labor [...] I think the structure has to be improved a lot, both pre-partum, childbirth and postpartum. A delivery room placed in the middle of a surgical center is inadmissible, it doesn't make any sense. The delivery room should be a different room, located apart from the surgical environment, because normal delivery is not a disease, it is a physiological process, so we had to treat it with more caution, with more attention. (RPH33)

An undergraduate student mentioned structural aspects and lack of humanization of pre-delivery in his speech:

Several issues such as inadequate hospital structure exist. The hospital has only two pre-delivery beds in a room with one bathroom. Women are practically thrown down into there. It's a very dehumanized environment. A better structure is needed for a more humanized childbirth. (S42)

DISCUSSION

Although most professionals knew how to define obstetric violence, the present study showed that some interviewees lacked knowledge about this subject. The professional category of nursing assistants was the one that demonstrated such deficit, which, according to the literature, is the result of the health professionals' resistance and the lack of knowledge of another form of care, configuring itself as an obstacle to the implementation of humanized care. Thus, the lack of familiarity with the theme characterizes the distancing from the principles of humanization.¹⁸⁻¹⁹

Part of the professionals defined obstetric violence through behaviors they deem as not recommended, without scientific evidence and attitudes that are contrary and disrespectful to the rights of pregnant women. Some institutional routines do not comply with good birth practices, making women "objects of care". Certain conducts adopted go beyond the scientific recommendations for care throughout the pregnancy and puerperal cycle, with abuse of technology and disrespect for the physiology of birth.²⁰

Acts of humiliation, swearing, coercion, embarrassment, jokes, or disrespectful comments to the women and the large occurrence of negligence or not providing information relevant to childbirth, or carrying out obstetric procedures without authorization, are in line with what is described in the literature as obstetric violence. Discriminatory and disrespectful healthcare practices are recognized by professionals and expected by women in maternity hospitals. Obstetric care becomes increasingly trivialized; even when dealing with such an important topic, the proposed interventions and changes are not being carried out.^{10,18-20}

Although some participants reported not having witnessed practices of obstetric violence, as many did not work directly in the delivery room (where most episodes occurs), most observed the

occurrence of this event and knows how to conceptualize it. Behaviors such as approaching women in the lithotomy position, using Kristeller's maneuver, episiotomy, prolonged fasting, use of oxytocin, tubal ligation without consent, and cesarean section without indication were highlighted. Professionals defined obstetric violence, even superficially, and recognized that it should not exist in institutions. However, obstetric violence was reported as a common practice.¹⁹

A study carried out with undergraduate students showed that, in general, healthcare students have little knowledge about this topic.²¹ Lack of knowledge about the subject can result in inferences without scientific knowledge, corroborating the results of this study.

Respondents in this study also suggested that, for the non-occurrence of cases of obstetric violence, training and updates on the subject should be offered. Training of health professionals would be the initial step and it should be based on scientific knowledge, encouraging confidence in the physiology of the woman's body and in the natural condition of birth, also providing scientific and legal support for necessary conducts in childbirth. Healthcare assistance that violates the basic rights of women is rooted in the country in the current model of childbirth and is growing due to the lack of inspections in the institutions by the health system and the inadequate training of some professionals. Changes are needed so that there is a guarantee of humanization of the practices of healthcare professionals from training.^{18-19;22-23}

The insertion of an obstetric nurse in the studied environment was cited as primordial, enriching, and humanizing. Obstetric nurses help to reduce unnecessary interventions and contribute to a comprehensive care.²² The insertion of obstetric nurses in hospitals is recommended by the World Health Organization, as their practice is based on holistic care and not only in interventions, contributing to the reduction of maternal mortality rates and minimizing the critical health situation of women in Brazil.²³⁻²⁴

Some interviewees highlighted that the physical structure of their institutions contributed to the occurrence of cases of obstetric violence. The obstetric center of the institution studied has been deactivated due to the lack of human and material resources, a result from the economic crisis. The pre-delivery beds are located in a room inside the obstetric unit, and spontaneous vaginal deliveries often occur in the beds or in the operating room. There is institutional unpreparedness to receive pregnant women, which proves that, without adequate structure, healthcare is affected, reflecting on the professional's performance and exposure to precarious conditions, which can be considered a violation of health workers' rights.¹⁸⁻¹⁹

CONCLUSION

There was a lack of knowledge about obstetric violence. Some professionals were not able to identify the actions consistent with this practice. A large part recognized practices that were not favorable to obstetric care and that inappropriate or poorly applied behaviors were routinely and strongly reproduced, contributing to the detriment of women's autonomy over their bodies. The replication of obstetric violence is still strong in Brazil. It is necessary to implement strategies that aim at safety and respect for the ethical rights of parturient women. The recommended practices must be implemented in public institutions that provide maternal and child care.

It was also observed that the practice of obstetric violence was favored by the scarcity of restructuring of the work process, poor work conditions, and work overload. Thus, humanization of care is configured as a resource that can contribute to reducing these influences. Therefore, it is considered opportune to promote training to help health workers become familiar with evidence-based childbirth conducts, promote professional awareness regarding physical and emotional issues experienced by parturient women, and enhance care based on the integrality of the human being to all women.

Furthermore, a contributing factor to humanized care is the inclusion of properly prepared professionals to offer care based on the person's well-being, one of them being the obstetric nurse. It is essential that public institutions that provide maternal and child care value the role of obstetric nurses as well as the one of the multidisciplinary team. It is necessary to invest in professional training strategies so that the team can provide humanized care. Besides, this study proposes that more research on the topic of obstetric violence is needed and must be carried out with multidisciplinary teams.

CONTRIBUTIONS

We inform that all authors contributed equally to the design of the research project, data collection, analysis, discussion, and the writing and critical review of the content with intellectual contribution and the approval of the final version of the study.

CONFLICT OF INTERESTS

Nothing to declare.

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