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OBSTETRIC VIOLENCE: A PRACTICE EXPERIENCED BY WOMEN IN THE PARTURITION PROCESS

VIOLÊNCIA OBSTÉTRICA: UMA PRÁTICA VIVENCIADA POR MULHERES NO PROCESSO PARTURITIVO

VIOLENCIA OBSTÉTRICA: UNA PRÁCTICA EXPERIMENTADA POR LAS MUJERES EN EL PROCESO DE PARTO

Lediana Dalla Costa[1], *Rafaela Dias da Silva*[2], *Jadieli Simoni Roll*[3], *Marcela Gonçalves Trevisan*[4], *Géssica Tuani Teixeira*[5], *Jolana Cristina Cavalheiri*[6], *Alessandro Rodrigues Perondi*[7]

ABSTRACT

Objective*:** to identify the practice of obstetric violence experienced in the parturition process. ***Method: exploratory-descriptive field research with a quantitative approach conducted in the Primary Health Care Units of a city in the southwest of Paraná. The selection of participants occurred through non-probability sampling, in which data collection took place between May and July 2019, using a closed questionnaire. The instrument was applied to 157 puerperae women, regardless of the puerperal period, in health units. The data received statistical-descriptive treatment by the Statistical Package for the Social Sciences version 25.0. The study was approved by the Ethics Committee. **Results:** it was observed that 52.9% had cesarean sections and 5.1% reported that shouting and criticism by health professionals were intense. About the acts of obstetric violence, the occurrence of kristeller maneuver (24.2%), frequent vaginal touches (41.4%), performed by several professionals (31.8%) and not allowing the ingestion of food or beverages during parturition(26.8%) were observed. ***Conclusion*:** there are violent acts in the care provided to the parturients. Thus, the importance of female empowerment and adherence to satisfactory obstetric practices is emphasized.

Descriptors: Violence; Obstetrics; Parturition; Humanization of Assistance; Healthcare Models; Nurse Midwives.

RESUMO

***Objetivo*:** identificar a prática da violência obstétrica vivenciada no processo da parturição**.** ***Método*:** pesquisa de campo, exploratória-descritiva com abordagem quantitativa e realizada nas Unidades de Atenção Primária à Saúde de um município do Sudoeste do Paraná. A seleção dos participantes ocorreu por meio de amostragem não probabilística, na qual a coleta de dados se deu entre os

meses de maio a julho de 2019, utilizando-se de um questionário fechado. O instrumento foi aplicado a 157 puérperas, independentemente do período puerperal, nas unidades de saúde. Os dados receberam tratamento estatístico-descritivo pelo programa *Statistical Package for the Social Sciences* versão 25.0. O estudo foi aprovado pelo Comitê de Ética. ***Resultados*:** observou-se que 52,9% realizaram cesariana e 5,1% relataram que os gritos e críticas, por parte dos profissionais de saúde, ocorreram de forma intensa. Acerca dos atos de violência obstétrica, constatou-se a ocorrência da manobra de kristeller (24,2%), toques vaginais frequentes (41,4%), realizados por vários profissionais (31,8%) e a não permissão da ingestão de alimentos ou bebidas durante o trabalho de parto (26,8%). ***Conclusão***: há atos violentos nos atendimentos realizados na assistência às parturientes. Ressalta-se, assim, a importância do empoderamento feminino e a adesão às satisfatórias práticas obstétricas.

Descritores: Violência; Obstetrícia; Parto; Humanização da Assistência; Modelos de Assistência à Saúde; Enfermeiras Obstétricas.

RESUMEN

Objetivo: identificar la práctica de la violencia obstétrica experimentada en el proceso de parto. ***Método*:** investigación de campo, exploratoria-descriptiva con enfoque cuantitativo y realizada en Unidades de Atención Primaria de Salud de un municipio del sudoeste de Paraná. La selección de los participantes se produjo a través de un muestreo no probabilístico, en el que la recogida de datos se realizó entre los meses de mayo y julio de 2019, mediante un cuestionario cerrado. El instrumento se aplicó a 157 puérperas, independientemente del período puerperal, en unidades de salud. Los datos recibieron tratamiento estadístico-descriptivo mediante el Statistical Package for the Social Sciences versión 25.0. El estudio fue aprobado por el Comité de Ética. ***Resultados*:** se observó que el 52,9% realizó la cesárea y el 5,1% relató que los gritos y las críticas, por parte de los profesionales de la salud, se produjeron de forma intensiva. Sobre los actos de violencia obstétrica, se observó la ocurrencia de la maniobra de kristeller (24,2%), toques vaginales frecuentes (41,4%), realizados por varios profesionales (31,8%) y no permitir la ingesta de alimentos o bebidas durante el parto (26,8%). **Conclusión:** hay ataques violentos en las atenciones realizadas en la asistencia a las parturientas. Resalta, pues, la importancia del empoderamiento femenino y la adhesión a las prácticas obstétricas satisfactorias.

Descriptores: Violencia; Obstetricia; Parto; Humanización de la Atención; Modelos de Atención de Salud; Enfermeras Obstetrices.

[1]Paranaense University/UNIPAR. Francisco Beltrão (PR), Brazil. [1] http://orcid.org/0000-0002-9114-3669

[2]Paranaense University/UNIPAR. Francisco Beltrão (PR), Brazil. [2] https://orcid.org/0000-0002-6157-2251

[3]Paranaense University/UNIPAR. Francisco Beltrão (PR), Brazil. [2] https://orcid.org/0000-0002-0093-9961
[4]Paranaense University/UNIPAR. Francisco Beltrão (PR), Brazil. [2] http://orcid.org/ 0000-0002-1703-7200
[5]Paranaense University/UNIPAR. Francisco Beltrão (PR), Brazil. [2] https://orcid.org/ 0000-0002-4479-1452
[6]Paranaense University/UNIPAR. Francisco Beltrão (PR), Brazil. [2] https://orcid.org/ 0000-0002-2001-8828

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INTRODUCTION

Motherhood is the beginning of a new cycle and is generally expected with great expectations. This process should occur in a physiological way, respecting the women´s choices, physical and mental integrity, feelings, and autonomy.[1] However, the way of giving birth has undergone important changes over time. Although they have brought important benefits, surgical procedures, the use of medicines, the presence of trained professionals, and technology have contributed to the dehumanization of birth and the increase in obstetric violence.[2]

Violence is represented as a serious social problem, manifesting itself through violent attitudes that affect the individual. Among the types of violence, obstetric violence stands out, defined as actions that violate birth assistance. At the same time, they hurt the principle of autonomy, by not allowing decision making during the parturition process, resulting in dehumanized actions that harm the quality of life.[3]

Obstetric violence violates human rights and directly implies maternal morbidity and mortality. It is characterized by physical, psychological, and verbal abuse, in addition to the use of unnecessary procedures that cause harm to the victims, such as episiotomies, trichotomy, routine oxytocin, bed restriction, Kristeller maneuver, deprivation of a companion, repetitive vaginal touches, among others.[4]

The current model of birth is marked by the medicalization of care, becoming interventionist.[5] In Brazil, around 87% of women suffer some type of violence during childbirth and birth.[6] Moreover, a study showed that the main acts of violence were contact with the baby postponed until after procedures (29.7%), immediate cutting of the umbilical cord (29.0%), and when the baby is taken away without explanations (27.7%). The supine position during birth and the use of oxytocin also stand out.[5,6]

Law Project No. 160/2018, which provides for obstetric violence, highlights the rights of pregnant and parturient women and revokes Law no. 19,207, of November 1st, 2017, which defines ob-

stetric violence as negligence in assistance, excessive and inappropriate treatment, coercion of the victim to inhibit denunciations committed by any health professionals from public and private institutions, and omission of pertinent information.[7]

The law also emphasizes the rights of humanized care, such as: gestational risk assessment; the presence of a companion; individualized treatment; preservation of intimacy; and the right to information. Furthermore, it must be visibly displayed to the public, enabling complaints in case of noncompliance.[7] The Ministry of Health has national guidelines for assistance to normal birth, with the objectives of providing guidance, promoting, and encouraging the humanization of care for parturient women, through good practices.[8]

The interdisciplinary team plays a fundamental role in the parturition process; it must help in a humanized, respectful, and welcoming way, offering active listening and providing autonomy, seeking to change the current scenario of obstetric violence.[2]

It is known that obstetric violence has always been in the obstetric context, however, nowadays it has been taking considerable proportions worldwide. This fact may be associated with new technologies and female empowerment, since the promotion of autonomy in pregnancy makes women seek their rights and start to demand them, giving greater visibility to the subject.

Due to the lack of studies, in the Southwest of Paraná, that can contribute to the clarification of these women about the reality and contextualization of violence during parturition, this subject becomes unanimous in our region. Thus, the identification of the main types of obstetric violence that occur in the region can contribute to the process of humanization in childbirth and birth.

In this context, the question is: What is the reality of obstetric violence experienced by puerperae in the parturition process in the hospital environment?

OBJECTIVE

To identify the practice of obstetric violence experienced in the parturition process.

METHOD

Field research, exploratory-descriptive, with a quantitative approach and carried out in Primary Health Care Units in a city in the southwest of Paraná.

According to data from the Brazilian Institute of Statistical Geography, the municipality has an estimated population of 89,942 inhabitants, with a territorial area of 735,111 km^2. Currently, it is composed of twenty Family Health Strategies, sixteen of which are in urban and four in rural areas, as well as two Basic Health Units and one Health Center. The sites were chosen for the study because they are part of the Primary Health Care of the municipality.

The participants of the study correspond to puerperal women assisted in different health units in the city during the data collection period, with a non-probabilistic, convenience sampling by means of a temporal variable, constituting the sample 157 women who agreed to participate and met the study criteria.

Puerperae with up to 45 days postpartum belonging to PHC and enrolled in the Paranaense Mother Network program were included, regardless of age, who delivered vaginally or by cesarean section in public and private maternity hospitals in the city. Underage participants were included upon authorization of a responsible person. Those who did not fit these criteria were excluded.

The selection of participants considered the puerperal women who returned to the health services for puerperal consultations, and the identification and control was done by a list provided by the nurses responsible for prenatal care.

Data collection occurred between May and August 2019. The participants were approached individually, and the structured questionnaire built by the researchers was applied in an interview format, which included the sociodemographic variables (age group, marital status, race, education, and family income), obstetric variables (whether they had prenatal care, type of health unit, number of prenatal visits, number of pregnancies, whether there was abortion, gestational age at birth, and current puerperium period), number of prenatal visits, number of pregnancies, whether there was abortion, gestational age at birth, current puerperium period, occurrence of complications during prenatal, birth, and puerperium), birth history (birth place, person responsible for birth, type of birth, preferences at the beginning and end of pregnancy, and the choice of birth route). Also, how intense were the experiences during birth (occurrence of threats, yelling, jokes, criticism and ironic comments, use of nicknames, and denial of the presence of a companion), the feelings experienced (whether she felt threatened, vulnerable, exposed or without privacy, at ease for questioning, and what was her level of satisfaction with the care), and the interventions performed (whether the woman went into labour, whether during childbirth the woman was prevented from walking or seeking a suitable position, whether a companion was present, whether enema, trichotomy, oxytocin use, more than four vaginal touches, vaginal touches performed by several providers, no food intake, artificial rupture of the membranes, Kristeller maneuver, episiotomy, cesarean section, immediate cutting of the umbilical cord, directed pulling during the expulsion period, parallel conversations, mechanical restraint, and postponement or prevention of mother-infant contact immediately after birth).

All ethical precepts were preserved in accordance with Resolution No. 466/2012 of the National Health Council. The research was submitted and approved by the Ethics Committee on Research

Involving Human Beings of the Paranaense University under opinion no. 3,291,378 and CAAE no. 11627519,0.0000,0109.

The data were described and tabulated in Excel spreadsheet and received statistical-descriptive treatment, using the Statistical Package for the Social Sciences (SPSS) version 25.0 for distribution of absolute and relative frequencies.

RESULTS

When considering the sociodemographic data, it was identified that in relation to age, there was a predominance of puerperae aged 20 to 34 years (69.4%). Regarding marital status, the main characteristic was the presence of puerperae in a stable union (59.9%) and white (61.1%). Regarding education, most had completed high school (39.5%), with family income of 1 to 2 minimum wages (43.3%) (Table 1).

Table 1. Sociodemographic data of puerperae belonging to Primary Care Units. Francisco Beltrão (PR), Brazil, 2019.

Variable	N	%
Age Group		
Up to 19 years old	25	15.9
20 to34 years old	109	69.4
> 35 years old	23	14.6
Marital Status		
Married	37	23.6
Stable Union	94	59.9
Single	25	15.9
Divorced	1	0.6
Race		
White	96	61.1
Brown	58	36.9
Black	3	1.9
Education		
Elementary School Incomplete	28	17.8
Elementary School Complete	5	3.2
Incomplete High School	32	20.4
Complete High School	68	39.5

Incomplete Higher Education	16	10.2
Complete Higher Education	14	8.9
Family Income		
< 1 minimum wage	31	19.7
1 to 2 minimum wages	68	43.3
> 2 minimum wages	25	15.9
3 to 5 minimum wages	28	17.8
>5 minimum wages	5	3.2

Source: survey data, 2019

When answering the questionnaire, 59.9% of puerperae were in late puerperium. The participants reported having had prenatal care (98.7%), in Family Health Strategies (73.2%), in more than 6 consultations (89.2%). About the number of pregnancies, 42.0% had only 1 child and 82.8% had never had an abortion. Moreover, regarding the period of birth, the majority classified 37 to 42 weeks (83.4%). Regarding complications during prenatal, birth and puerperium, 66.2% did not present them; however, systemic arterial hypertension (SAH) (8.3%) and other pathologies (12.1%) were present (Table 2).

Table 2. Obstetric data of puerperae belonging to the Primary Care Units. Francisco Beltrão (PR), Brazil, 2019.

Variable	N	%
Realization of prenatal care		
Yes	155	98.7
No	2	1.3
Unit of prenatal care		
Family Health Strategy	115	73.2
Basic Health Unit	42	26.8
Number of consultations		
From 1to 2	2	1.3
From 3 to 4	1	0.6
From 5 to 6	14	8.9
> than 6	140	89.2
Number of pregnancies		
1	66	42.0
2	57	36.3

3	26	16.6
3 or more	8	5.1
Abortion		
Yes	27	17.2
No	130	82.8
Gestational Age at Birth		
Pre-term	18	11.5
Term	131	83.4
Post-term	8	5.1
Puerperium Period		
Immediate	42	26.8
Late	94	59.9
Remote	21	13.4
Complications during prenatal, birth **and puerperium**		
Yes	53	33.8
No	104	66.2
Type of complications		
SAH	13	8.3
Pre-eclampsia	1	0.6
Gestational diabetes	9	5.7
Placental abruption	11	7.0
Others	19	12.1
Did not present	104	66.2

Regarding the type of birth, the largest number of births took place in public institutions (96.2%), being mostly performed by obstetricians (93.6%), in which the type of birth was the scheduled cesarean section (37.7%). Despite this, it is observed that both at the beginning of pregnancy (74.5%) and at the end (71.3%) women preferred normal birth. On the other hand, women who underwent cesarean section alluded that they preferred vaginal birth at the beginning of pregnancy but changed their minds due to medical indication (33.1%), while those who had vaginal birth as an outcome had this route of parturition as their preference at the beginning of pregnancy (37.7%) (Table 3).

Table 3. Birth history and desire of birth route of puerperae belonging to Primary Care Units. Francisco Beltrão (PR), Brazil, 2019.

Variable	N	%
Place of birth		
Public Hospital	151	96.2
Private Hospital	6	3.8
Professional who conducted the birth		
Obstetric Nurse	9	5.7
Obstetrician	147	93.6
Obstetrician	1	0.6
Type of birth		
Normal without induction	23	14.6
Normal with induction	41	26.1
Cesarean section after going into labor	9	5.7
Scheduled Cesarean section	56	35.7
Emergency Cesarean section	28	17.8
Preference on type of birth at the beginning of pregnancy		
Normal birth	117	74.5
Cesarean section	40	25.5
Preference on type of birth in late pregnancy		
Normal birth	112	71.3
Cesarean section	45	28.7
Cesarean birth		
Desired	34	21.7
Normal birth but changed your mind	3	1.9
Had a normal birth and changed your mind due to a doctor's recommendation	52	33.1
You had a C-section against your will	2	1.3
Other	2	1.3
Not applicable	64	40.8
Normal birth		
Wanted	56	35.7
I wanted a C-section but changed my mind	4	2.5

You wanted a C-section, but changed your mind due to a doctor's recommendation	3	1.9
You wanted a C-section, but the birth was against your wishes	3	1.9
Not applicable	91	58.0

The experiences and feelings experienced by the participants were classified according to intensity. When asked if anyone had threatened them, 98.1% said they had not been threatened. Likewise, 93.0% mentioned that there was no yelling from the professionals. However, 5.1% reported that the shouting and criticism for their whining and crying occurred in a very intense way. Regarding the attitude of professionals, the participants denied the occurrence of orders to stop yelling (92.4%), jokes (98.7%), ironic comments (96.2%), unpleasant nicknames (99.4%) and preventing the presence of the accompanying person (94.9%). Moreover, 88.5% did not feel at ease to ask questions, because they did not answer or answered poorly.

However, it is worth mentioning that 3.8% felt intensely threatened by the speech or attitude of some professional. The feelings of vulnerability, inferiority, insecurity occurred very intensely for 14.0%. When asked if they had felt without privacy, the majority said no (84.7%). About the level of satisfaction with the team that assisted them, 86.0% felt very satisfied (Table 4).

Table 4. Experiences of puerperae about the behaviors adopted by health professionals during the parturition process. Francisco Beltrão (PR), Brazil, 2019.

Variable	N	%
Threats		
Did not occur	154	98.1
1 to 5 - Occurred with low intensity	2	1.3
6 to 10 - Occurred in a very intense way	1	0.6
Shouts		
Did not occur	146	93.0
1 to 5 - Occurred with low intensity	3	1.9
6 to 10 - Occurred in a very intense way	8	5.1
Commanded to stop shouting		
Did not occur	145	92.4
1 to 5 - Occurred with low intensity	5	3.2
6 to 10 - Occurred very intensely	7	4.5

Made a joke		
Did not occur	154	98.7
1 to 5 - Occurred with low intensity	1	0.6
6 to 10 - Occurred very intensely	2	1.3
Criticism for whining and crying		
Did not occur	149	94.9
1 to 5 - Occurred with low intensity	2	1.3
6 to 10 - Very intense	6	3.8
Ironic comments		
Did not occur	151	96.2
1 to 5 - Occurred with low intensity	2	1.3
6 to 10 - Occurred very intensely	4	2.5
Called by nickname		
Did not occur	156	99.4
1 to 5 - Occurred with low intensity	1	0.6
It prevented the presence of a companion		
Did not occur	149	94.9
1 to 5 - Occurred with low intensity	2	1.3
6 to 10 - Occurred very intensely	6	3.8
You felt uncomfortable asking questions because they didn't answer you or answered you poorly		
Did not occur	139	88.5
1 to 5 - Occurred with low intensity	9	5.7
6 to 10 - Occurred very intensely	9	5.7
Felt threatened by the speech or attitude of a professional		
Did not occur	147	93.6
1 to 5 - Occurred with low intensity	4	2.5
6 to 10 - Occurred in a very intense way	6	3.8
She felt vulnerable, insecure, inferior		
Did not occur	111	70.7
1 to 5 - Occurred with low intensity	24	15.3
6 to 10 - Occurred in a very intense way	22	14.0
Felt exposed or without privacy		
Did not occur	133	84.7

1 to 5 - Occurred with low intensity	9	5.7
6 to 10 - Occurred very intensely	15	9.6
Satisfaction with the team that attended		
Did not occur	1	0.6
1 to 5 - Occurred in a low intensity	21	13.4
6 to 10 - Occurred very intensely	135	86.0

Regarding the interventions and conducts practiced by health professionals during labor, it was observed that in 53.5% of the deliveries, the spouse was prevalent as companion. Regarding good obstetric practices, we observed exposure to interventions that should be used sparingly, such as immediate cutting of the umbilical cord (81.5%), use of oxytocin (29.3%), artificial rupture of the membranes (22.9%) and performing episiotomy (20.4%). Regarding interventions not recommended, repeated vaginal touches in less than 60 minutes (41.4%), performed by several professionals (31.8%), and occurrence of the kristeller maneuver (24.2%) were evidenced, the impediment of food or drink consumption during birth (26.8%), the restraint of hands (33.8%) during the cesarean section, parallel conversations by the professionals (36.6%), and the newborn was carried without the mother's consent (24.8%). Furthermore, it was found that the newborn was not in direct contact with the mother during the first hour of life (64.2%) and that breastfeeding was not allowed during the first hour (54.1%) (Table 5).

Table 5. Interventions adopted by health professionals during the parturition process. Francisco Beltrão (PR), Brazil, 2019.

Variable	**N**	**%**
You went into labor		
Yes. went into labor	84	53.5
Did not go into labor and had a cesarean section	73	46.5
During labor		
You were unable to walk	6	3.8
You were unable to find a suitable position	5	3.2
Did not occur	146	93.0
Presence of a companion		
Only the woman	17	10.8
Without a companion	26	16.6
Mother	18	11.5

Spouse	91	58.0
Godmother	1	0.6
Others	4	2.5
Enema		
Yes	1	0.6
No	156	99.4
Trichotomy		
Yes	5	3.2
No	152	96.8
Use of oxytocin		
Yes	46	29.3
No	111	70.7
Repeated vaginal touches in less than 1 hour		
Yes	65	41.4
No	92	58.6
Vaginal touches performed by several professionals		
Yes	50	31.8
No	107	68.2
Prohibited from eating and drinking		
Yes	42	26.8
No	115	73.2
Artificial rupture of amniotic sac		
Yes	36	22.9
No	121	77.1
Kristeller Maneuver		
Yes	38	24.2
No	119	75.8
Episiotomy		
Yes	32	20.4
No	125	79.6
Cesarean section		
Yes	83	52.9
No	74	47.1
Immediate umbilical cord cutting		

Yes	128	81.5
No	29	18.5
During the expulsion period		
She was deprived of adopting a comfortable posture	4	2.5
You were pulled by professionals	8	5.1
Doesn't know Doesn't remember	40	25.5
Did not occur	105	66.9
During the cesarean section, the abdomen was cut before the anesthesia took effect		
Yes	3	1.9
No	154	98.1
Parallel conversations among professionals		
Yes	57	36.3
No	100	63.7
Had their hands tied		
Yes	53	33.8
No	104	66.2
Performed procedures without consent		
Yes	8	5.1
No	149	94.9
Immediately after birth had contact with the postponed baby		
Yes	98	64.2
No	59	37.6
Your baby taken to the procedure room without explanation		
Yes	39	24.8
No	118	75.2
Was forced to breastfeed or bond		
Yes	10	6.4
No	147	93.6
Impeded or hindered breastfeeding in the first hour		
Yes	85	54.1
No	72	45.9

DISCUSSION

Many advances in good obstetric practices are already being instituted. However, the current model of childbirth and birth assistance still comprises numerous conducts performed without the necessary need or without precise indications. It is noted that the protagonist in labor is not being respected, even with the recommendations of the National Program for Humanization of Prenatal Care.[5]

The pregnancy-puerperal cycle exposes women to several diseases that are closely related to causes of maternal and neonatal morbidity and mortality. The Ministry of Health, through Public Policies and Programs, reinforces the humanization of health practices during this period.[9]

When analyzing the sociodemographic data, it was found that the women were in the reproductive phase and aged between 20 and 34 years. Similar data were found in another study whose puerperae were aged between 20 and 35 years. When analyzing the sociodemographic data, it was found that the women were in the reproductive phase and aged between 20 and 34 years. Similar data were found in another study whose puerperae were aged between 20 and 35 years.[10]

Regarding marital status, it was evidenced that there was a predominance of puerperal women with a partner. A study also found similar data (83.0%) and showed that the father figure is of considerable importance for strengthening the bond with both the mother and the newborn, making the father transmit security in a stage of difficulties.[11]

Regarding skin color, a predominance of white was observed, diverging from the study carried out in Bahia, where blacks prevailed. This fact is justified by the colonization of each region. Moreover, it was found that in both surveys the puerperal women had complete high school education.[12]

The level of education is closely related to the level of understanding and insertion in the parturition market, directly implying the financial condition, quality of life, and health status of women. It is noteworthy that the higher the mother's education, the greater the adherence to the consultations. Undoubtedly, prenatal care is essential for reducing the development of maternal and child morbidities and deaths from preventable causes.[13]

It is found that there is great adherence of puerperae to prenatal care, corroborating the study conducted in São Paulo, in which 99.6% were in follow-up, totaling more than six consultations. The study also stresses the importance of the implementation of the Prenatal and Birth Humanization Program, to humanize the assistance and provide better adherence to consultations.[14] The World Health Organization and the Ministry of Health recommend at least six prenatal consultations, aiming at reducing maternal and neonatal morbidity and mortality rates.[15]

When considering that the highest adherence to consultations occurred in Family Health Strategies, the importance of continuous assistance to families and effective active search is mentioned. It is important to emphasize that Primary Care Units provide services on demand and perform their services in a more comprehensive way.[16]

Regarding motherhood, the expectations and experiences of birth can influence the choices in future pregnancies, so it is essential that there is a qualified listening at this important moment. Regarding the number of pregnancies, first pregnancies prevailed. A study conducted in the city of Alagoas, Brazil, identified data that are in line with this study, when most parturient also reported being their first experience.[17]

In the postpartum period, which begins at the time of expulsion of the placenta and lasts until the 42nd day after the birth of the child, several complications can occur in the cardio-vascular, integumentary, respiratory, hematopoietic, endocrine, and reproductive systems, including maternal deaths from preventable causes. Thus, it is necessary to monitor women at this stage through the puerperal consultation.[11]

Considering that among the complications, a significant portion of puerperal women developed SAH, the importance of adherence to control measures of this grievance is highlighted. It is known that the most frequent causes of maternal death are direct obstetric ones, especially hemorrhages (54%), followed by hypertensive syndromes (46%).[18]

Currently, there is an effort to rescue the humanization of birth, which unfortunately was lost with the introduction of various technologies. It is known that humanization means welcoming the mother, respecting her individuality, and not intervening in natural processes with unnecessary care practices, valuing women.[19]

Unfortunately, despite the efforts of the Ministry of Health and the humanization movements, the high rate of scheduled cesarean sections in the survey is remarkable, which may in turn be associated with the lack of indications through scientific evidence.[8] The World Health Organization recommends that only 15% of births be performed by scheduled or emergency cesarean sections. But in Brazil, 56% of births take place by surgery, disrespecting this recommendation.[20]

Factors such as the evolution of surgical and anesthetic techniques, reduction in the risk of immediate postoperative complications, remuneration, and the choice of birth route by pregnant women may justify the high rates of cesarean sections in Brazil, as well as their feasibility.[21]

Although obstetricians are responsible for the largest number of births, obstetric nurses are also legally qualified to assist in birth at usual risk. However, it is emphasized that there is still resistance to the autonomy of this professional in hospitals of the Brazilian Unified Health System.[22]

This preference is justified by the faster maternal recovery, the option for a normal and healthy birth for mother and child, easier breastfeeding, among others.[23] However, in the present study, it is evident that their choices were not respected, considering the high rate of cesarean sections when compared to vaginal birth.

It is noteworthy that a significant portion of puerperae changed their minds due to medical indication. It is suggested that fear of the pain of vaginal birth, previous negative experiences, and the desire to perform a sterilization procedure may also have interfered in the choice.[17]

Therefore, women's experiences are considered an influential point in the choice of delibery route due to their first experiences. But for many women, the process of giving birth occurs in a disrespectful way, especially when health professionals do not understand their individualities, difficulties, and limitations.[24]

Although most of the puerperae reported satisfaction with the care provided by the health team and said they did not receive threats, a significant portion considered that the criticism of professionals in relation to their complaints occurred very intensely. It is known that the term obstetric violence is not only configured as physical violence, but also as psychological, and may occur during prenatal, birth, and postpartum. Therefore, yelling and insults are considered acts of violence.[24]

A study identified that 21.6% of pregnant women received criticism for crying and screaming during labor and 19.5% did not exacerbate their emotions for fear of mistreatment and were subjected to jokes related to their behavior.[25] Although the data from this study are not so expressive, they are relevant, since these behaviors are inadmissible and are at odds with the humanization policy.

Women with low family income and blacks are more likely to suffer discrimination in birth care and violence. And, even with the presence of a companion, this act is practiced, but in smaller proportion.[26]

Although most women were accompanied, it was identified that the absence of a companion was reported by 27.4% of puerperae. In this context, it is suggested that the lack of knowledge about the rights of pregnant women and the current law contribute to such numbers. Including, to defend the presence of the companion, the draft Law No. 160/2018 was developed, which provides on obstetric violence, rights of the pregnant and parturient woman.[9]

Undoubtedly, the absence of a companion can intensify feelings of fear, insecurity, and loneliness during birth and postpartum. It is essential that professionals perform a humanized care considering the woman's decision, so that birth is not a traumatic event.[27]

A study identified that obstetric practice has become mechanized, in which the woman is submitted to various procedures as if it were an assembly line, going through moments that violate the physiology of birth.[6]

Regarding interventions in labor, another study also showed that the parturient were unable to walk and had directed pulls.[6] It is known that the practice of walking during parturition contributes to the positive evolution, since it helps dilation. Furthermore, spontaneous pulls should be supported, and directed pulls should be avoided. If the spontaneous pull is ineffective, other strategies should be offered to assist birth, such as encouragement and change of position.[8]

Regarding obstetric interventions using oxytocin, it is worth emphasizing that its practice should not be used as a routine, but rather indicated for situations in which integrative conducts are not resolutive, requiring a pharmacological prescription.[8]

However, when oxytocin is released physiologically through lactation, it is beneficial to the body by promoting uterine contraction, contributing to its involution.[28] Oxytocin, if used intramuscularly and in low doses, is considered a preventive factor in postpartum hemorrhages, and may have a 50% decrease in cases.[18]

It is possible to evidence that interventions in labor are presented in smaller proportions when compared to other studies, which can be justified by the awareness of health professionals. However, a survey showed several interventions that did not consider the woman's autonomy, among them, the compulsory lithotomy position (91.7%), followed by episiotomy (56.1%) and kristeller maneuver (37.3%).[29]

It is also emphasized that there was no interaction between the mother-child binomial in the first hour after birth. Mother-child contact in the first hour of life is indispensable, because besides promoting safety, it can prevent postpartum hemorrhages, especially when associated with breastfeeding.[18]

Undoubtedly, the nurse is the professional whose actions are performed in a humanized way. Due to their academic training, they seek to promote quality care based on ethical principles. However, the low adherence to good obstetric practices may be justified by the current model of health care that is based on authoritarianism and interventionism, not promoting the empowerment of the mother.[30]

Despite being a currently emphasized theme, violence, in general, is described as a global health problem. Combating gender violence is among the goals of sustainable development and is still a challenge, since even with so many public policies present in our midst, interventions still occur in an exaggerated manner.[30]

It is worth mentioning that, although the number of interventions that occurred in the research is not expressive, it should be considered, since it was observed that women are often afraid to report what they suffered. Finally, it is evident, as a main limitation, the lack of knowledge of the

parturient about the care practices to which they were submitted and the obstetric conducts that directly imply violent acts that are performed during birth.

CONCLUSION

It was identified that the non-adoption of good practices, the routine conducts of hospital environments, and obstetric violence were present in the daily life of the parturient women and directly infringed upon the woman's autonomy during labor. Their choices and wishes for a normal birth at the beginning and end of pregnancy were not respected, leading to cesarean section in more than half of the parturient women.

The study made it possible to visualize the current scenario of birth, in which puerperae still suffer acts of obstetric violence due to the mechanistic model that does not allow autonomy in the process of birth, resulting in unnecessary interventions. It is, therefore, up to obstetric nurses to empower themselves in relation to birth, ensuring better adherence to good obstetric practices. It is emphasized the importance of updating the professionals in relation to the conducts performed so that there are changes in the care, based on policies directed at the humanization of care and laws that regulate the assistance to parturients.

Furthermore, the importance of female empowerment, women's experience of birth as a positive experience, and adherence to good obstetric practices for childbirth and birth care is emphasized to reduce these actions committed without due necessity.

CONTRIBUTIONS

All authors made an equal intellectual contribution to the research design, data collection, analysis, and discussion, as well as to the writing and critical review of the content and approval of the final version of the study.

CONFLICT OF INTERESTS

Nothing to declare.

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Correspondence

Lediana Dalla Costa
E-mail: lediana@prof.unipar.br

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