



## ORIGINALES

### Forms of obstetric violence experienced by mothers who had normal birth

Formas de violência obstétrica vivenciadas por puérperas que tiveram parto normal  
Formas de violencia obstétrica experimentada por madres que tuvieron un parto normal

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#### ABSTRACT:

**Objective:** Identify forms of obstetric violence experienced by mothers who had normal birth.

**Methods:** Descriptive study with a qualitative approach, developed with 35 puerperal women, in both public maternity hospitals existing in the city of Natal, Rio Grande do Norte, Brazil, who gave birth by vaginal delivery with a live child, and physical and emotional conditions to answer the proposed questions. adolescents were excluded without legal guardian and mothers who gave birth outside the hospital.

**Results:** The reports of mothers portray forms of obstetric violence of which they were victims, characterized by words and attitudes of health professionals who attended them.

**Conclusions:** Under the new delivery care model and birth obstetric violence should have no space and health professionals should act to ensure decent service, with quality and respectful treatment. The time when the only option was silencing and enduring has ended.

**Keywords:** Natural childbirth; Maternal health services; Violence against women; Women.

#### RESUMO:

**Objetivo:** Identificar as formas de violência obstétrica vivenciadas por puérperas que tiveram parto normal.

**Método:** Estudo descritivo, com abordagem qualitativa, desenvolvido junto a 35 puérperas, nas duas maternidades públicas municipais existentes na cidade de Natal, Rio Grande do Norte, Brasil, que tiveram parto pela via transpélvica, com filho vivo, e em condições físicas e emocionais para responder aos questionamentos propostos. Foram excluídas adolescentes sem responsável legal e puérperas que pariram fora da maternidade.

**Resultados:** Os relatos das puérperas retratam as formas de violência obstétrica da qual foram vítimas, caracterizadas por palavras e atitudes dos profissionais de saúde que as assistiram.

**Conclusões:** No âmbito do novo modelo de assistência ao parto e nascimento a violência obstétrica não deve ter espaço e os profissionais de saúde devem atuar no sentido de garantir um atendimento digno, com qualidade e tratamento respeitoso. O tempo em que a única opção era silenciar e suportar chegou ao fim.

**Palavras chave:** Parto normal; Serviços de saúde materna; Violência contra a mulher; Mulheres.

## RESUMEN:

**Objetivo:** Identificar las formas de violencia obstétrica experimentadas por las madres que tuvieron un parto normal.

**Método:** Estudio descriptivo, con un enfoque cualitativo, desarrollado con 35 puérperas, en dos maternidades públicas municipales existentes en la ciudad de Natal, Rio Grande do Norte, Brasil, que tuvieron parto vaginal, con niño vivo, y en condiciones físicas y emocionales para responder a las preguntas propuestas. Fueron excluidas las adolescentes sin tutor legal y las puérperas que dieron a luz fuera del hospital.

**Resultados:** Los informes de las madres representan las formas de violencia obstétrica de las que eran víctimas, que se caracteriza por las palabras y actitudes de los profesionales de la salud que las asistieron.

**Conclusiones:** En el marco del nuevo modelo de asistencia al parto y al nacimiento, la violencia obstétrica no debería tener espacio y profesionales de la salud deben actuar para garantizar un servicio decente, con una calidad y un trato respetuoso. El tiempo en que la única opción era el silencio y soportar llegó a su fin.

**Palabras clave:** Parto normal; Servicios de salud materna; Violencia contra la mujer; Mujeres.

## INTRODUCTION

During the parturition process, many women are victims of abuse and disrespectful treatment within health institutions. This reality, which affects several countries in the world, besides violating the rights of these women to quality care, puts their physical and mental integrity at risk in a moment of extreme uniqueness. Thus, in addition to a public health problem, there is a human rights issue<sup>1</sup>.

Violence, whether physical, emotional or symbolic, produces a high degree of suffering<sup>2</sup> and, sometimes, presents in such a subtle way that hinders its recognition and, consequently, gives greater prominence to the subject<sup>3</sup>. In this context, obstetric violence comprises any action that produces negative physical and psychological effects during the natural parturitive process. Most of the time, its materialization occurs through a dehumanized treatment coming from health professionals<sup>4</sup>.

Through this reality, it is necessary to understand the meaning of obstetric violence, which is not an easy task due to the innumerable conceptualizations that have arisen in recent years. One of them, present in the legislation of Venezuela, pioneer in Latin America when making obstetric violence illegal, affirms that this type of violence is "appropriation of the body and reproductive processes of women by health personnel, expressed in a dehumanizing treatment, in an abuse of medicalization and pathologization of natural processes [...]"<sup>5:30</sup>.

In Brazil, a survey of Brazilian women and gender in public and private spaces showed that 25% of the interviewees were victims of obstetric violence<sup>6</sup>. Another study, developed in a maternity hospital in São Paulo, Brazil, showed a similar percentage, 27.9%. Expressions of violence were described as unexplained procedures or authorization granted (27.3%) by women, such as episiotomy, artificial amniotomy and enema. There were also failures in clarifying doubts (16.3%) and prohibition regarding the presence of the companion (9.3%)<sup>7</sup>.

When analyzing the presence of obstetric violence associated with unrecommended practices in the care of vaginal delivery, the results are worse. There was a prevalence of 86.57% at a school maternity unit in the Northeast region, being the main detrimental practices the efforts of pulling (65%), administration of oxytocin (41%) and routine use of supine position (39%)<sup>8</sup>.

This reality is in opposition to the recommendations of the World Health Organization, which advocates the occurrence of a normal birth, spontaneously, without inductions, in which the parturient has the right to privacy, respect for her choice of place of birth, empathic service providers, presence of an accompanying person, freedom of position, encouragement of non-supine positions, and lack of water restriction<sup>9</sup>.

Thus, the Brazilian obstetric model, marked by the need for a rapid delivery, which, in some situations, forgets respect for women's autonomy, favors the occurrence of unnecessary interventions, based on practices without scientific evidence that support them, a condition that favors the occurrence of obstetric violence<sup>10</sup>.

Identifying forms of violence is a way of recognizing the existence of the problem and the way it manifests. Thus, the results of this study may contribute to the elaboration of strategies able to mitigate the current problems present in the obstetric scenario. In addition, they will serve as parameters for the analysis of other realities that present a similar picture. The aim of this study was to identify the forms of obstetric violence experienced by puerperal women who had normal birth.

## **MATERIAL AND METHOD**

This is a descriptive study, with a qualitative approach, which interviewed 35 mothers. This research is part of the project entitled "Normal Childbirth Assistance: A Quality Assessment" developed in the two municipal public hospitals operating in Natal, Rio Grande do Norte, Northeastern Brazil, during the months of March to July 2014. These maternities were chosen because they represent public obstetric care offered to pregnant women in cases of normal-risk childbirth, making them a favorable field for the investigation of the object of study.

The inclusion criteria were puerperal women who had a transpubertal delivery, with a living child, and in physical and emotional conditions to respond to the proposed questions. Adolescents without legal guardians and puerperal women who gave birth out of the maternity were excluded.

The selection of the participants occurred by oral invitation during a visit to the joint accommodation. Initially, the objectives of the research were presented, as well as its relevance, highlighting the importance of participation. Upon acceptance, the on-site interview began, with prior reading and signing of the Informed Consent Form. The researchers clarified that, at any time, the participants could request the exclusion from the research without damages of any nature.

The interviews were numbered according to their order of occurrence, and the number was later used for coding, in order to guarantee the anonymity of the puerperal women.

The collection instrument contained questions about the sociodemographic characteristics, obstetric history, and information on the current pregnancy and on the

fact that the puerperal woman had felt or felt intimidated and/or embarrassed by some word or expression mentioned by health professionals. Therefore, the semi-structured interview was chosen.

The Content Analysis according to Bardin<sup>11</sup> was used, which involved the following steps: pre-analysis; exploitation of the material; and treatment of results, inference and interpretation. During the pre-analysis, the written statements of the participants were organized based on the rules of completeness, homogeneity and pertinence and, later, a floating reading was made to apprehend the initial impressions of the material, followed by successive readings in order to identify the recording units. The exploitation of the material allowed grouping the data by similarity, allowing the identification of its characteristics. Finally, the information was treated, making it meaningful and valid. After this process, two categories emerged: words and attitudes. The study followed the ethical principles of research, complying with Resolution #466/12 of the National Health Council. The Research Ethics Committee of the Federal University of Rio Grande do Norte approved the project under #562,313, dated February 28, 2014, and Certificate of Presentation for Ethical Appreciation: 25958513.0.0000.5537.

## **RESULTS**

This section presents the sociodemographic characteristics of the participants and the thematic categories resulting from their speeches.

### **Characteristics of the puerperal women**

The interviewed puerperal women were between 18 and 36 years old, from the pardo ethnicity (21 participants), had education from 4 to 16 years, lived in consensual union (20 participants), followed by married (9 participants) and had income ranging from less than one minimum wage to eight minimum wages. The minimum wage at the time the interviews occurred was R\$ 724.00. Primiparous prevailed (19 puerperal women) and 34 had prenatal care, generally beginning in the third trimester (25 puerperal women) and with a number of consultations ranging from one to 13. They were all attended by a health professional and gave birth at a gestational age between 37 and 41 weeks.

The reports of the puerperal women are described below and depict the forms of obstetric violence suffered by them, characterized by the words and attitudes of the health professionals who attended them.

### **Words**

There were several occasions during the parturition process that obstetric violence was present. Inappropriate comments, from some health professionals, reflect a little humanized care that profoundly marks the experience of delivery and childbirth.

She (professional) kept recriminating me for the number of children I have. She kept saying: "she still wants more" (E30).

The doctor acted with ignorance. She told me I was not ready to give birth (E14).

The professional (nursing technician) got there and did not introduce herself, she already started to handle my saline solution, she was harsh and showed much lack of humanization (E29).

I told them to call for her (doctor) three times, but they did not believe I was giving birth for I had got there a short time before. When she came and saw me, she said: "come on, come on", but I was having a contraction and told her to wait. She did not care at all (E8).

Likewise, criticism of screaming or groaning during labor was present in the puerperal women's responses. These manifestations, reflecting the singularity and expression of each interviewee, regardless of first pregnancy, or not, were strongly questioned. Those who testified that they had cried and moaned were subjected to intimidation, including the threat of being left alone at a time of considerable frailty.

The nursing technician told me that, if I kept screaming, she would leave me alone (E16).

The doctor told me to stop moaning, for that was a magic moment and I was making it painful, passing the suffering for those around me (E33).

The doctor told me: "you make scandal, cry, and make noises. In the first one, you did not even do it" (E21).

"You do not have to scream, you just have to keep forcing". When I told her I was passing away: "pass way, just do not stop forcing" (E23).

### **Attitudes**

The interviewed puerperal women reported the problem of pain. Pain is regarded as something inherent in the parturitive process and part of the physiological mechanisms of childbirth. In addition, other pains may be present at that time. One example is the pain caused by the way the vaginal touch is performed and the one caused by episiorrhaphy or even by the healing process, as described below:

The doctor called me naughty and dirty. After your sixth child, you cannot support this pain (at the touch time). The person can have 10 children, but she will always feel pain. Having six children is not a reason for not feeling pain (E13).

The doctor said that I was complicating, I was not making it easy. The touch was hurting. Instead of facilitating, I was complicating. I said it was hurting (E20).

I felt pain during the stitches and I told the doctor, but he said he had already given anesthesia and could not do anything. So I told him to do his job, but it was hurting, yes, it was (E2).

When I complained about the stitches pain (joint lodging), the technician said: "you have to feel the pain and will still feel more" (E31).

The birth position was another factor that generated uncomfortable situations for the interviewees. The difficulty in staying in a position convenient for the professionals led women to be, at times, treated with ignorance, and even psychologically pressured by the responsibility for some possible harm to the child.

The doctor with shouts, tugs and ignorance told me to be quiet and open my legs, otherwise I would hurt the child (E15).

The doctor, ignorant, said: open your legs further (E11).



The nurse told me not to close my legs, otherwise I would kill the baby (E4).

## DISCUSSION

In view of the presented reports, it is clear that the relationship established between professionals and the parturient, seen as harsh and distant from what the movement advocates for the humanization of childbirth, rekindles several discussions. One of them concerns the perception of violence by the individuals involved in the process, especially by those who practice it.

Sometimes, the use of pejorative and repressive sentences is confused as a way of exercising authority in the institutional environment. This evidences attitudes based on gender relations that historically compromise the right of women<sup>12</sup>. In an attempt to impose themselves, professionals forget the most important, and the real reason why they are present at that time: to provide assistance, support and help.

During childbirth, the woman needs attention, clarification about the procedures, respect and empathy, and, above all, the possibility of participating actively in this phase of her life<sup>13</sup>. However, when these attitudes are not present, the outcome of delivery and childbirth may be unfavorable, sometimes representing a negative experience in the life of the experiencer.

Likewise, behavior of this nature reflects failures in the formation of those that feed an obstetric health system with many deficiencies, marked by the execution of procedures without the necessary scientific support<sup>14</sup>. This process results in the labor market entry of professionals who are unable to recognize women's needs during the birth process. Equally, the impact of their attitudes and words on such a special occasion in a woman's life becomes unnoticed.

The statements also reveal a relationship of power between professionals and parturients, who are in a clear level of inferiority. In this condition, they had their pain silenced by fear, and those who should provide support and aid threatened them.

The screams and moans annoy the professionals, because most of the times they reveal the need for attention, aimed at reassuring the woman or even clarifying her doubts about the process of birth. When this is not possible, silencing seems to have been the quickest and most efficient option to solve the problem. In this way, the parturient is vulnerable to different types of violence.

Study on institutional violence from the perspective of users in maternity hospitals in São Paulo, Brazil, portrayed the parturient as 'scandalous'. This attribute features the woman who screams, does not force and/or often triggers the team. For the interviewees, they are more likely to be underserved, with the only option of being silent<sup>15</sup>. When a woman silences, it is not only the pain she tries to omit, but also her fears, her longings, her doubts. This is the clearest example of repression suffered by women during the process of parturition: not being able to express themselves freely in their uniqueness on an occasion of discomfort, especially caused by the pain of labor.

Regarding pain during childbirth, it is a subjective sensory experience and its level varies according to the singularities of each person. During labor, the pain felt by the woman is predictable. However, since each one experiences it differently,

professionals must respect the individuality of each parturient<sup>16</sup>. The fact that this physiological pain is part of the process opens in the minds of professionals the conception that any other type of pain is also acceptable and that the woman must support it. This becomes clear when observing that the interviewees' speeches do not deal with the physiological pain of childbirth, something reported in other studies<sup>17-19</sup>. Meanwhile, some of the interviewees mentioned the pain from procedures inserted in the obstetric field.

Once again, the woman is forced to endure any kind of pain and those who do not are harassed. Breaking with the idea that childbirth is synonymous with pain and suffering may be, perhaps, the first step in understanding the pains of this moment in another way and with the sensitivity that the moment demands.

In terms of delivery in a lithotomy position, it gives a scenario built in favor of the professionals, and not for the woman. Sometimes, this is the only option she has to bring her child to the world<sup>20</sup>. Childbirth care training considers this position as a reference, as well as the books that deal with the mechanisms inherent in vaginal delivery. In addition, it facilitates the professional to monitor fetal heart rate. However, the woman feels more participative when she can choose the position that most suits her needs<sup>21</sup>.

Forcing the woman to give birth in a lithotomy position or not offering other options denotes the suppression of freedom and imposition of power. Lying at a complete disadvantage, she finds herself at the mercy of the professionals who have the opportunity to impose their facilities, disregarding the needs and desires of the parturient. This context marks the defeat of female empowerment, freedom of choice and control of her own body.

## CONCLUSIONS

In the context of the new model of care for delivery and childbirth, which is gradually attempting to be instituted, as opposed to the hegemonic model, obstetric violence must not have space. If it has remained invisible for a long time, becoming inherent in the process of delivery and childbirth, it, nowadays, appears in its various forms of manifestation. The present study identified violence whose revelation occurred through words and attitudes from professionals who work with the parturient.

When recognizing the existence of this serious problem that affects women in the most distinct places in the world, one must also seek coping strategies. It is not just empty, unpretentious, words or attitudes, but marks that can be imprinted on the souls of these women throughout their lives. If its impact is considerable, the penalties imposed on those who practice obstetric violence should also be considerable. Criminalizing it, like other forms of violence against women, can be an alternative in the search for solutions for this problem.

In addition, health professionals must act in order to guarantee a decent service, with quality and respectful treatment, considering the rights won by women in the obstetric field. Likewise, difficult working conditions cannot be accepted as justifications for obstetric violence. The time when the only option was silencing and enduring has ended.

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