Obstetric violence for professionals who assist in childbirth

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Abstract

Objectives: to know the perception of obstetric violence for professionals who assist in labor and delivery.

Methods: the research was qualitative. Research participants were 22 professionals providing or assisting women during labor and delivery. The sample was defined by data saturation. The analysis of the data collected was performed using the proposed content analysis of Bardin.

Results: five categories were identified, professionals highlighted the existence of a process of change in childbirth care and the importance of respecting physiology and intervening when necessary. It was evident that verbal violence is one of the most recurrent forms of obstetric violence. The factors identified as determinants for the existence of violence were the interaction between the parturient and the team, the professional's lack of preparation and institutional problems. Even with several statements about obstetric violence, some professionals stressed not experiencing it in practice.

Conclusions: the need to invest in strategies to inhibit obstetric violence and humanize care is perceived through training professionals and guiding women on their rights.

Key words *Humanizing delivery, Violence against women, Obstetric violence, Humanization of assistance*

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Introduction

The birth of a child is very important and significant, since it has a direct relationship with renewal of life and is one of the most intense experiences in women's life. The assistance offered to the parturient contributes directly to a positive or negative experience of this process of birth and has remarkable effects on both mother's and baby's lives. Thus, the professional should focus on the care to women's needs, observing their rights, autonomy and protagonism.[1,2]

The rights of women in the gravidic-puerperal cycle are frequently being violated by institutions and health professionals, characterizing, thus, institutional violence. The ruling obstetric assistance is currently permeated by the impossibility of women to execute their autonomy, also by the increase of technical and technological intervention and the use of cesarean section.[2-4]

Institutional violence that occurs in maternity hospitals is denominated obstetric violence, a term used for all varieties of violence and damages that occur during obstetric assistance. It is characterized by disrespect to women's rights and has multiple aspects such as: omission, negligence, physical and psychological violence, sexual abuse, interventions and medications without scientific evidence and other situations that generate suffering to women and may harm their children.[5,3,6]

Many professionals involved in the gravidic-puerperal cycle may be responsible for obstetric violence, but mainly physicians and nursery team, since they are responsible for the care offered to the mother-fetus binomial. The violence is present regardless of the type of delivery taken, as it may occur in vaginal delivery or cesarean delivery.[7,8]

Inadequate assistance to women contribute significantly to morbimortality of women and children. The World Health Organization estimates that 295,000 women die every year in consequence of complications related to maternity.[9,10]

In order to ensure humanization of assistance, it is necessary to incorporate good practices during prenatal period, labor and puerperium. According to WHO guidelines, women's healthcare should provide women with autonomy, respect to their rights, support with empathy, promotion of non-invasive and non-pharmacological methods for pain relief, freedom to assume positions of their choice, scientific evidence-based attitudes and constant professional update.[11]

In view of the importance of humanized assistance during the entire pregnancy, labor and delivery, it is necessary to answer the following question: what is the perception of professionals that act in labor and delivery assistance about obstetric violence?

Answering this question may help health students and professionals that act in assistance to both women in gravidic-puerperal cycle and newborns to comprehend the violence phenomenon and the importance of humanization to assure the binomial's health and to prevent obstetric violence. We intend, by disclosing these data, to improve the assistance offered to mothers and newborns. This study aimed to comprehend the perception about obstetric violence of professionals that act in labor and delivery assistance.

Methods

This is an exploratory, descriptive and cross-sectional study of qualitative approach. The research was conducted at Itajubá municipality, located in the South of Minas Gerais state. The participants were 22 professionals that assist or assisted women during labor and delivery. Nurses, obstetric nurses, nursing technicians and obstetric physicians were included, acting in private or public service. The sample size was determined by data saturation, when authors identified redundancy or repetition of information.[12]The sample in this survey was intentional or purposive.

The eligibility criteria were: having experience with assistance to women during labor or delivery in hospital environment, performing two or more assistances; having assisted women during labor or delivery after 2015, that is, after municipal adherence to *Rede Cegonha* (Stork Network). Exclusion criteria were: having assisted women during home delivery and having assisted only women that underwent cesarean section.

Data collection was carried out in the period between July and September 2018. In order to find the professionals, Snow Ball technique was used, when the first participant indicated the next one and so on.[12]

At the day of interview, the Free and Informed Consent Form was exposed and explained and the interview was carried out only after authorization and signing the form. Data collection was performed by means of filling a form about personal and professional characterization of the participant and had the following variables: sex, gender, age, occupation, highest degree, and time working in labor and delivery assistance. Afterwards, a semi-structured interview was performed, with the following guiding question: "What is your perception about obstetric violence in labor and delivery assistance?"

Data collected in the recorded interviews were transcribed entirely and analyzed using Bardin content analysis. The different stages of analysis are based in three aspects: pre-analysis, exploration of material and treatment of results.[13]

At the pre-analysis the organization of data was performed, a moment that aims to systematize ideas. First, floating reading of data was performed, which allowed the contact with these data and then knowing the text, producing impressions and orientations. After exhausting reading of data, the next stage started: the identification of codes. With defined codes, the categorization was established, moment of classifying data by differentiation and afterwards, by regrouping according criteria established at the previous stage.[13]

In order to keep anonymity, participants were identified by the letter "P" from the word "professional", followed by the cardinal sequence number according to the order of interviews. This article is part of the research titled "Meaning and perception of obstetric violence for professionals that act in labor and delivery assistance". The study followed the prescription established by Resolution n° 466/2012 from Ministry of Health and was approved by the Research and Ethics Committee of Wenceslau Braz Faculty, from the city of Itajubá-MG, under opinion 2.401.429, CAAE 80069417.3.0000.5099.

Results and Discussion

The profile of professionals was 16 women (72.7%) and 6 men (27.3%). The predominant age range was that of 31.9% with 28 to 33 years, followed by the range of 22 to 27 years (27.3%), 46 to 51 years (13.6%). The mean age was 36.3 years. Regarding occupation, there was a predominance of nursing technician, with 45.5%, followed by physician, with 31.8% and nurse, with 22.7%. The mean time of assistance to women during labor and delivery was 9.7 years. Concerning the type of service, 5 (22.57%) belonged to private service and 17 (77.2%) to public service.

The following categories were listed: 1) Process of change, 2) Respect physiology and intervene when necessary, 3) Aggressive effect of words and Result of parturient-and-team interaction, 4) Lack of preparation of professionals and Institutional problems and 5) From non-recognition to damages.

Process of change

The professionals highlighted the existence of a process of change in assistance to delivery by means of the incorporation of attitudes and practices of humanization. Obstetric violence permeates obstetric assistance for years, even if a particular woman had not experienced violence within her gravidic-puerperal cycle, she listens to reports from other people.

> *"I had never witnessed violence, but I heard a story from my mother, as I said, they just encouraged her to not want to have more children [...]"* (P19)

The obstetric practice hasbeen going through expressive changes in the last 20-30 years, with emphasis on the encouragement of the use of natural and physiological properties of the birthing process. Many procedures came to be questioned, due to the lack of scientific evidence and for making women uncomfortable. The environment also has been suffering alterations, becoming more hospitable, allowing women and their families to participate and demonstrate expectations.[14]

According to the speech of participants, although obstetric violence has been present in assistance for many years, there is an effort to promote changes and humanize assistance. The process of humanization has been ensuring benefits to women due to the spread of information, surveys on the theme, professional preparedness and awareness of women.

> *"Nowadays, humanized birth has been chosen and worked out better, the patient has been understanding that it takes just a little more time than a birth with medication and the labor is a little slower, but the patient has been understanding this and feeling that it is better to stay in a much more hospitable place, she can have her companion there, all of this helps and gets the patient more relaxed."* (P2)

> *"Nowadays, in my perspective, it decreased a lot due to news and policies that guide women's safety. In the past, obstetric violence was common in healthcare institutions."* (P9)

> *"So, the professionals nowadays are more engaged into resources society has, such as the internet, a massive network of surveys in this field, so professionals are getting into the obstetrics area, already experiencing all of this, how it should be made [...]* (P17)

However, some professionals claimed that improvements are needed, since women are still suffering obstetric violence.

> *"The process of labor and delivery humanization has already improved significantly, it was a more severe problem in the past. Although it still needs attention, since there are mothers that still suffer with this."* (P7)

> *"Obstetric violence still occurs significantly in hospital environments, causing embarrassment to women; however, this may change, leading women to labor and delivery in a harmonious way."* (P10)

The humanized assistance model propitiate women familiarity with birthing process and has as a goal the

decrease of cesarean sections and maternal and perinatal morbimotality.[15] However, it is currently possible to verify that women pass through many disrespectful practices in labor and delivery assistance, associated with the excessive use of techonolgy.[15,16]

Respect physiology and intervene when necessary

Narratives of diverse areas from Brazil mention the frequent use of oxytocin, artificial rupture of membranes and manual dilation of cervix to quicken the dilation process, followed by directed pushes, episiotomy, Kristeller maneuver and forceps to accelerate the stage of expulsion.When these maneuvers do not result in vaginal delivery of the newborn or in case of suspect of fetal distress, cesarean section is performed.[17]

As a consequence of this model of care, the birthing process ceases to be seen as an individual and physiological event and returns to be a moment of experiences, most of the time negative. In this context, professionals face the birthing process as a pathological phenomenon, adequate for interventions.[18]

The professionals affirm the importance of respecting physiology and intervene when necessary, thus abandoning mechanized routine practices. According to participant P18, the mechanistic approach of assistance enabled obstetric violence to be quotidian and seen as natural.

> *"The mechanistic approach of assistance to patients unfortunately allowed obstetric violence to be frequent and seen as natural, during the process. Yet humanization has been changing this scenario every day, promoting more safety and quality for mothers and children at this period."* (P18)

It is evident in the following discourses that in specific situations, during labor, the physician should take attitudes that preserve the lives of mothers and babies. For them, practices considered interventionist, when used in adequate manner, ensure benefits.

> *"And another thing, vaginal delivery, in spite of being the physiological delivery, less risky than a surgical delivery, but there are dangerous situations, sometimes the rupture of a vessel, hemorrhage, you need to act quickly, if you don't have technical knowledge to do that, how can it be done? [...]"* (P5)

> *"[...] such a situation in which the main thing is common sense and you should respect the other person and demonstrate to her that everything you do is necessary, and if it is really necessary, why it can't be restrictive and end of it, this can't be done."* (P5)

There is scientific evidence that several practices in labor assistance lead to better obstetric results, and are satisfactory concerning the decrease of negative perinatal outcomes, when used with indication. An important part of the complications that can occur during labor and delivery can be diminished by adequate obstetric care, executed with the proper use of technology. Still, the inadequate use of technology or the execution of unnecessary interventions may result in impairments for both mother and child.[19]It is known that induction and unnecessary cesarean surgeries are one of the factors associated with prematurity rates.[17]

Aggressive effect of words and result of parturient-team interaction

Verbal violence is characterized by the use of offensive sentences, reprehensions, threats against mothers and children during labor. Alterations in voice tone are frequently performed by professionals, as well as the use of words that bring humiliation, pejorative terms and jokes. Although many professionals are against such attitude, verbal aggression is still present in assistance.[20]

Research conducted in maternity hospitals in the city of Natal observed that inadequate comments performed by some health professionals denote poorly humanized assistance. It was reported by parturients the existence of professional criticism on the act of screaming or moaning during labor. Those who confirmed having emitted screams or moans, passed through moments of intimidation, threats of being let alone, in addition to being severely questioned.[21]

Corroborating the literature, it was evident that among many types of existing violence against parturients at the moment of delivery, one of the most recurrent is verbal violence. This issue can be observed in the speech of professionals P3 and P12, when defending that women should have the freedom of expression during delivery, since if there is pain it is normal to scream.

> *"I think that words also have an aggressive effect in relation to delivery, in the way that they are spoken, for example, there is plenty of obstetricians that talk like "when you made it you didn't feel any pain at all, now that it's coming out, it's gonna hurt", a kind of detonating sentence towards the parturient."* (P3)

> *"I think that women shouldn't be cursed during delivery, in case of a scream or expressing pain anyway, I consider that ignorance and lack of respect from the professional that act in such a manner."* (P12)

Therefore, it can be comprehended that many times, pejorative and repressive sentences are wrongly used by professionals who understand this as a manner of demonstrating authority. During delivery, women need care and empathy, and when it lacks, the outcome is unfavorable, becoming a negative experience.[21]

There is difficulty in implementation of a humanized model of assistance to delivery and birth because, besides being necessary modifications in practices and protocols, it is important to reconsider relationships between professional staff, parturients and relatives.[22]

The events of violence that are harder to note occur in the field of the relationships between professionals and patients, involving discrimination and loss of autonomy. These kinds of violence are commonly conceived in rude speeches, disrespectful in relation to parturients and in neglect regarding the need for analgesics and adequate use of technology.[7]

The interaction parturient-team is established as indispensable for the existence or not of obstetric violence. It is perceived in the speech that obstetric violence occurs by means of an inadequate manner of approaching women, disregarding their pain and concerns about being assisted.

> *"I think it is the way of treating the parturient, there is such stupid people 'came here in pain?' 'Couldn't wait any longer at home to dilate and then come with a good dilation?' 'It's only one finger, why did you come now?'"* (P3)

A research conducted in maternity hospitals in São Paulo region identified difficulties in the interactions of professionals and patients. Some professionals demonstrated a perspective of the users of public service as ignorant, with difficulties of understanding what is being said and with a sexuality that is hard to control.[7]

It was perceived as a discourse marked by the belief of the professional regarding the scarce knowledge of patients and companions. We also highlight the regretful perspective about the physician on call at maternity, since "he will be in contact with ignorant people".

> *"Poor doctor on duty, I feel so sorry about such doctors, because he sometimes deals with situations of ignorant people that he had never seen, that come in a mess. In the other day, there was a husband of a patient that kicked the maternity wall, made a hole at the wall, after he had to pay for that.But you see how the doctor on duty sometimes suffer, sometimes the level of ignorance is very high. They don't valorize the work of a doctor on duty [...]"* (P4)

In order to establish a good relationship, confidence and equality among the involved individuals is needed. In the speeches, it is evidenced that the ideal would be the professional that follows the parturient during prenatal to also provide assistance during labor and delivery.

> *"Brazil's future would be the one that performed prenatal, performs the delivery, or instead a large harmonization of the entire team."* (P3)

> *"In many times, violence occurs when the patient doesn't know the doctor and the relationship is not very good, and then obstetric violence arises, I have followed my patients since the first prenatal consultation."* (P4)

The relationship between professionals from the health staff is also identified by some participants as important factors for the experience of obstetric violence or not.

> *"Violence doesn't occur when a team is synchronized, make the work together, well-coordinated, there is no obstetric violence, it exists when this good following is lacking, the patient is not well-informed."* (P4)

Research conducted in maternity hospitals from the public network of the Midwest region of Minas Gerais made evident the limits determined by the physician/nurse hierarchy in hospital institution, limiting and controlling their access in assistance to delivery.[23]At the top of hierarchy is the physician, seen as those who possess the highest technical-scientific authority.[7]

Teamwork is necessary, since the care of human beings is a complex activity, and being so, needs the inclusion of knowledge and practices of various professional categories, generating new manners of assistance. Multidisciplinary work allows the team to offer integrative assistance.[24]

Lack of preparation of professionals and Institutional problems

An integrative review about obstetric violence identified that the most discussed themes in the analyzed studies were institutional lack of preparedness and professional qualification. The limited knowledge about practice based on evidence favors the mechanized practice and the perspective of woman as an object.[20]

The findings of the research corroborates to aforementioned review, since in face of the obstetric violence context, interviewees perceived as a determinant factor the lack of preparedness of professionals to deal with diverse situations met in assistance.

"I think that sometimes it is the lack of information in university, the way it was taught, because many times the doctor does what was taught to him, in the academic life he learned that way. It's about changing the base of teaching, and this is what is changing now, the gynecology and obstetrics courses are largely getting into area of care, of humanized birth, and ends up taught how to treat and deal, because sometimes it can be made without the notion that this is a violence, because he was taught to do that, and this is a multiprofessional issue, nursery and pediatrics as well." (P2)

"This is why I that the greatest violence is not having preparedness for that thing you are doing [...]" (P5)

Assistance that violates rights of women is linked to the model of delivery in force in the country, based on flaws of healthcare system that does not seek to execute necessary supervisions in institutions and on defective qualification of some professionals.[18] Violence against women may be influenced by the lack of institutional preparation in various factors, such as: precarious qualification, lack of permanent education in healthcare, structural difficulties, disorder of services, practices based on scientific evidence and assistance guidelines.[16,25]

In this category, participants affirmed that institutional problems contribute to the existence of obstetric violence, highlighting the lack of proper environment and adequate resources, in addition to overcrowding and presence of few professionals. Professionals stressed that, in order to assure quality in women's care, the maternity hospital should have adequate physical structure and sufficient and qualified human resources.

"*It happened many times, being in a C-section and a vaginal delivery is occurring in maternity, and I have to split myself in two, I believe that vaginal delivery can be performed by obstetric nurses, or by the student, and my concern is there, because there was a C-section and I come and see that the delivery didn't occur as well as expected, because of the overcrowding. It has already happened 13 births in a night, not always you'll be able to assist everybody, you need to designate each person.*" (P3)

"So I think the greatest violence is actually not having minimal conditions for the patient to be assisted, it needs to start having a good maternity, graduated and qualified professionals, this will be exchanged in safety." (P5)

Survey conducted in maternity hospitals in São Paulo region evidenced, as difficulties met with the execution of assistance, the overcrowding in the health service, the structural situation and the lack of human and material resources. These difficulties imply in lack of anesthesiologists on duty to perform birth analgesia, as well as the prohibition of masculine companions in labor room, under the justification of small physical space that allow privacy for other patients.[7]

From non-recognition to damages

Although violence is a phenomenon in ascension, having space in society and media, it still veiled, in a particular way in health services, in which professionals deal with situations of power and gender, and protect aggressors or hide the facts, fearing to generate conflicts and hostility.[22]

It was observed that, despite several speeches regarding obstetric violence, some professionals stressed having not experienced it in the institution in which they work. Interviewee P5 stresses perceiving violence as a heavy term to define conducts, since he believes that the use of this word is an attempt of labeling.

"I don't have much experience with obstetric violence because it doesn't occur with me [...]" (P4)

"I sincerely see violence as a very severe word, obstetric violence, people have this habit of trying to label, I don't see this [...] (P5)

Obstetric violence is comprehended as a heavy and depreciative term and have been causing indignation among obstetric physicians, because of the belief that the term denotes a certain hostility to these professionals and may collaborate to nullify all technical improvements incorporated by medical assistance.[26]

It is proven the existence of veiled violence, hidden by ideological naturalization of the exercise of professional power over patients.[20] Authoritarian behaviors, use of pejorative language, threats and censoring against women are common in the assistance quotidian of maternities, although hidden.[23]

Professional P5 affirms that obstetric violence depends on the context, demonstrating that a search for justifications for violenceexists. Still there are attitudes of violence that are not assessed and recognized by professionals.

"Sometimes, something that has the meaning of a more severe thing for oneself, may not have it at all for others.But it's what I'm saying to you, in many times, certain attitudes and conducts may have been excessive for some, and not for others, it depends on the situation. It is a manner of talking, of touching, it is the explanation, it's about really doing what is supposed to be done." (P5)

> *"I see that many times it is executed and not even considered as such by professionals that commit it, they not realize that the laughter at the moment of seeing the patient's vagina is something compelling for her, they don't understand that saying no to some need of her is a bad thing, or be disgusted when she does her physiological needs, feces, at the time of delivery, some professionals don't understand [...]"* (P18)

The health professional has difficulty of self-recognition as the originator of obstetric violence, transforming the practice in natural actions, justifiable and necessary, that would supposedly be done for the well-being of patients and newborns.[27]

Studies conducted in Brazil corroborate the findings of this research, when evidencing that existence of a veiled kind of violence. Violence consented by women was identified as well, as interventions conducted during labor are perceived as part of a good assistance. Between professionals, it was noticed violence witnessed by nurses and then silenced. On the other hand, the physician presents a discourse that neglects violence when ensures that it does not happen in the same extension nor has the repercussion that is conceived by media and other organizations.[23,28,29]

There is also the trivialization of parturient's suffering, which consequently leads to trivialization of institutional violence, present in sentences under the excuse of jokes. The difficulty for health professionals to identify violence in assistance is perceivable also in the idealization of some that violence would imply a greater severity of the act, causing intentional physical or emotional damage. However, ironic, moralist and prejudiced sentences, usually spoken as a "joke" are understood merely as humor.[7]

Trivialization of obstetric violence is a consequence of the lack of listening of professionals, of depreciation of women's speech and absence of appropriate technology. In order to revert this situation is indispensable that professionals retrieve the recognition that birth is a significant period in the life of each woman.[25]

The study demonstrated that obstetric violence occurs due to a mechanistic perspective of the reproductive process, where standardized conducts are incorporated to quicken the stage of expulsion. Nevertheless, there is also the existence of a change process coming from the movement of humanization of delivery and birth. Although important modifications had occurred in assistance, improvements are still needed.

We highlight the importance of respecting physiology and intervene when necessary, abandoning mechanistic and routinely practices. The parturient/team interaction was described as indispensable for the existence or not of obstetric violence. It was also evident that among many varieties of violence, one of the most recurrent is verbal violence.

Interviewees perceive as a determinant factor the lack of preparation of the professional, to deal with the various situations found in assistance. Professionals highlight that institutional problems contribute to the existence of obstetric violence, such as the lack of environment and adequate resources, in addition to overcrowding and presence of few professionals. Lastly, we evidenced that although there are many speeches about obstetric violence, some professionals stressed not having experienced that in practice.

In order to change this reality of violence in obstetric assistance, professionals point to preparation of professionals, with the inclusion of obstetric violence discussion in undergraduate courses, as well as specialization and permanent education. It is important to unveil this theme and make it discussed and recognized, and thus decrease its occurrence.

Another highlight in professionals' speeches was the need for offering conditions that contribute to a more hospitable environment and violence free. For this, it is necessary physical adequacy, availability of human and material resources, besides qualification to the involved staff.

Not only professionals should be prepared, it is also necessary to guide women about their rights, so that they can come empowered and capable to comprehend the moment of birth. Knowledge is one of the main challenges to obstetric violence. It is a stress point for qualification to prenatal assistance, an adequate moment for health education.

Therefore, it is interesting that managers and professionals from the municipality of study invest mainly in strategies of qualification of the staff and in health education for women.

We suggest that there is higher supervision in the public sector about the situation of assistance to institutionalized births, being aware of routinely and unnecessary practices, contributing to the fight against violence. Brazil is expected to continue the development of this struggle, creating laws for punishing thoseresponsible.

Authors' contribution

Bittencourt AC: conception and/or design of the project, data collection, analysis and interpretation of data and writing of the article. Oliveira SL: data collection, analysis and interpretation of data. RennóGm: conception and/or design of the project, analysis and interpretation of data and critical review of the manuscript. All authors approved the final version of the article and declared no conflict of interest.

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