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OBSTETRIC VIOLENCE: EXPERIENCES OF PUERPERAL PRIMIPARAE IN A PUBLIC MATERNITY

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ABSTRACT

The present study aimed to identify situations of obstetric violence during labor. It is an interpretative case study in which the data were collected through a semi-structured interview in the homes of fifteen puerperal women who delivered the child in a public maternity hospital in the municipality from Regional Health Center located in the State of Goiás. The interpretative thematic analysis was carried out through the stages of reduction, organization of data, identification of meaningunits, construction of thematic nucleus and interpretation of results. The results were organized in two thematic nucleus: experience during the initial phase of labor and the experience of the puerperal woman during the expulsive phase of labor. It was observed from the study participants' reports that during labor there was at least one form of obstetric violence in which care was based on ineffective interventions and without the consent of the patient..

Keywords: Violence Against Women. Labor. Humanizing Delivery. Perinatal Care. Qualitative Research.

INTRODUCTION

The process of parturition, throughout history, have gone through several changes. Traditionally, births were performed at home by midwives; all of them without the presence of a male and in the upright position. With technological innovation, deliveries began to take place in the hospital, with yhe beginning of the hospital delivery culture because it was safer and offered more qualified assistance. In this scenario, the use of invasive and often unnecessary techniques, such as the use of routine episiotomy and the increase in the number of elective cesarean section, are observed[1].

However, from another perspective, guided by scientific evidence and in favor of humanized birth and humanizing birth, the World Health Organization (WHO) in the 2000's published the "Practical Guide to Assistance to Natural Childbirth" in which it recommends respect to the physiological process and the dynamics of each birth[2]. In Brazil, the most recent publication of the Ministry of Health, the "HumanizaSUS - Humanization of labor and Birth" book recommends to be minimal intervention and respect for childbirth as a physiological and unique process in the woman's life, partner and their families[1].

Since then, the Ministry of Health's goal has been to reduce maternal and perinatal mortality, guarantee quality and access to prenatal care and childbirth and puerperium care, as well as improve actions aimed at pregnant women and postpartumcare[1].

Despite these guidelines, a number of researches on women's experiences have shown physical violence, deep humiliation and verbal abuse during pregnancy, childbirth and postpartum in several countries, coercive or non-consensual medical procedures, serious violations of privacy and negligent care in health institutions during childbirth[3,4]. In Venezuela, these events are called obstetric violence and are criminalized in penal codes[5]. In Brazil, the issue of obstetric violence has been addressed in actions of different instances of the Public Ministry and in judicial action, but it is not yet considered a crime in Brazilian legislation[6].

This sort of violence against women has been conceptualized as any act carried out by health professionals, regarding the body and the reproductive processes of women, due to dehumanized care, abuse of interventionist actions, medicalization and pathological transformation of the physiological processes of parturition[6].

Given this scenario, it is believed that knowing the

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way that childbirth care has been done, under the perception of women, it is central to allow the elaboration of strategies to improve health actions and ensure compliance with the humanization guidelines proposed by the Ministry Health, ensuring better indicators of maternal and perinatal health.

This way, the objective of this study was to identify situations of obstetric violence during labor in a public maternity hospital).

METHODOLOGY

It is an interpretative case study conducted according to the methodological assumptions of modern hermeneutics, and that considers knowledge as a historical construction of dialogical and intersubjective social relations between the researcher and the participant. The central concern of this type of scientific research is to describe and explore one or multiple cases in their actual context to understand its complexity[7].

To select the participants, a survey of postpartum women in the immediate postpartum period was carried out at the joint acommodation unit of a public maternity hospital, located in the municipality of Jataí, Southwest Region Health II, in the state of Goiás, from September 2015 to March 2016.

The following inclusion criteria were considered: puerperal women who were 12 years of age or older, primiparous, single term fetus, and who had a normal delivery at the obstetric center of the institution. The exclusion criteria werepuerperal women with mental disorders or cognitive deficits and puerpera whose babies died.

The interviews were scheduled by telephone contact, 30 days after the birth, in which the study participants were informed about the interview at their home between 40 and 45 days postpartum, and that those under age should be accompanied by a person responsible. During the interview, care was taken to prevent the person responsiblefrom interfering with the minor's parturient's narrative. Of the 25 women who had been contacted, eight refused to participate because they had returned to the municipality where they lived and two were not found through telefone contact, after three attempts on different periods and days.

Fifteen individual semi-structured interviews were carried out in depth between October 2015 and March 2016, taking into account the recurrence of the information obtained by theoretical saturation of the data. The interviews were conducted by the main investigator, under the supervision of one of the researchers with expertise in collecting qualitative data, at the participants' home, based on a script that included socioeconomic variables (age, marital status, race, occupation, schooling, and number of prenatal visits), and the following guiding questions: Tell me how you experienced the waiting room and delivery room. How was the care given by the health professionals during birth?

The interpretative analysis was implemented by means of the exhaustive reading of the descriptions of each case and the transcripts of the interviews, which assured the researchers a impregnation of the data. The qualitative analysis was carried out considering the steps of data reduction and organization, construction of the units of meanings, identification of the thematic nucleus and interpretation of the results, constructed from the participants' narrative, the theoretical reference, the researchers' perceptions and reflections[7].

To give greater validity to the study, data processing and analysis were performed independently by two researchers, who discussed differences of interpretation. The whole process of interpretation was conducted collectively through discussion, review and re-elaboration of descriptions and interpretations.

The study participants had their identity protected by fake names in order to preserve anonymity. Each respondent was assigned the name of a woman who integrates the history of the feminist movement around the world. Thus, the excerpts from the narratives presented are followed by the given name.

The research was approved by the Research Ethics Committee of the Federal University of Goiás under protocol no. 965.374/2015. All participants signed the Free and Informed Consent Term (TCLE) or the Free and Informed Assent Term (TALE).

RESULTS AND DISCUSSION

The study participants had a mean age of 20.7 years (SD=2.08), and an average of 8.7 (SD=1.3) prenatal consultations done. Regarding to marital status, nine (60%) were in a stable union and six (40%) were single. As to race, 12 (80%) declared themselves to be brown colored skin. About the occupation, nine (60%) stayed at home, five (33.3%) had formal work and one (6.6%) was a student. Regarding family income, 11 (73.3%) reported earning from one to three minimum wages. As for schooling, nine (60%) had completed high school.

Through the interpretative analysis, it was verified that the experience of the puerpera was marked by a process that involved a habit-based delivery assistance, without scientific evidence, thus demonstrating the need to guarantee adequate training for health professionals and ensure the rights of the pregnant woman to the information on all the procedures to be performed at the time of delivery. This way, the following thematic nucleus were identified: "Experience of the puerpera during the initial phase of labor" and "Experience of the puerpera during the phase of expulsion of labor".

Experience of the puerpera during the initial phase of labor

In this nucleus, were grouped the reports on disrespectful communication by health professionals in the pre-deliveryroom, the performance of traumatic interventions, considered ineffective, the disregard for the pregnant woman's privacy and the prohibition of the male companion in the pre-deliveryroom.

Some participants reported some ways of hostile treatment and communication, with verbal aggression to pregnant women, at the momento f birth, when they expressed their suffering, either with crying, screaming or groaning, which evidenced the disregard of health professionals(6), as shown in the following narratives:

> [...]Well, I feltI did not know. as if I were an animal, I did not like it at all ... the way she (the doctor) treated me, she just said: "Get up there I'll see how many centimeters (dilation)". When I got down I ... (interviewee started to cry) I slipped ... I almost fell, she (doctor) said: "Can´t you see the ladder there?" And I was hurting, oh my... [...] I found it very wrong for her to sleak like that (the doctor) sometimes the word attacks the person more than a slap, a kick, a punch! (Margaret Fuller - 20 years old)

> [...] the night nurses told me not to shout, because it was not going to solve it. I thought it was not supposed to be like that,because it's kind of hard not to scream, whoever has had a natural birth knows how much it hurts, the night nurse was the one that most asked me not to scream (Leonor from Aquitaine - 20 years old)

Some procedures considered to be ineffective or unnecessary(1), such as the orientation of directed pushing (when the laborer performs abdominal contractions to expel the fetus under the guidance of a health professional) and amniotomy (artificial rupture of the amniotic sac to accelerate labor) the without the consent and clarification of the parturient, occurred during the initial phase of labor, as reported by the participants:

> [...] she (nurse) only explained that when the contractions were stronger, I could push because it would help to dilate faster. (Margaret Fuller - 20 years old)

> [...] it was eight centimeters and the bag had not ruptured naturally, but she (nurse) did not explain to me why she was going to break (the bag), just said: "I'll break your bag to go faster!" [...] (Margaret Fuller - 20 years old)

There is no scientific evidence that amniotomy decreases the duration of the first stage of labor(8). In addition, there is no consistent data that can define the best time to perform artificial rupture of the amniotic sac to accelerate uterine dilatation. Therefore, this procedure is not recommended as part of quality care for women in labor[8].

The use of synthetic oxytocin in order to accelerate labor and to perform numerous and painful touches to check the dilation of the cervix were also reported by the parturients:

> [...] the touches and the I.V solution .(oxytocin) werereally unpleasant [...] the cut hurts even til today ... (Joan of Arc - 20 years old)

> [...] they put that I.V solution on me (oxytocin) ...it seems to be tearing you up ... There was a moment that he (doctor) touched ... Wow, it hurted. I would say: "For God's sake, how many more times will you do this?" (Malala Yousafzai - 16 years old)

The practices of vaginal touches were frequent and performed by more than one professional. It is known, however, that these touches when carried out repetitively can bring discomfort to the parturient, besides not making sense when performed by several professionals, since it is possible to asses the evolution only by one professional[1].

It is also aggravating the indiscriminate use of oxytocin that increases uterine activity and may result in fetal hypoxia, associating with a cascade of subsequent interventions such as amniotomy and episiotomy[1,9,10].

In addition to these techniques, the participants mentioned the disrespect to privacy and the prohibition of the male companion in the maternity pre-delivery room, which did not have individual rooms. Thus, they all stayed in the same room during the first phase of labor, as described in the statements below:

> [...] the doctor told me that the companion should be a woman, but by law can be a man or a woman, we choose it [...]. They did not let my husband in (in the pre-delivery room) [...], but he (husband) said he knew his rights and entered (in the pre-delivery room) (Marie Curie – 23 years old)

> [...] I did not think there had to be that many people by the door because it was looking like a show [...] I thought that because it was a public hospital, privacy was not going to be respected, but there should be respect at least a little bit [...] (Leonor of Aquitaine - 20 years old)

> [...]It was a little strange that so many people (in thepre-delivery room), and pain at the same time, everyone (parturients) having baby together at the same time. [...] (Billie Jean King – 20 years old)

The right to the escortat the pregnant's choice during the period of labor, delivery and immediate postpartum is guaranteed by law[11]. Ensuring them, therefore, this right, makes them more confident, satisfied and happy, reducing the feeling of loneliness, anxiety and vulnerability of women[12].

Since the maternity of the present student had a single pre-delivery room for all the women, this hempered the parturients' privacy and, consequently, made it difficult for the staying of the companion. It is believed that the reorganization of this room, plus the posture of health professionals, is reoriented to the paradigm of humanization, is central to guarantee this right[1].

The essence of theword "humanizing" demonstrates the paradigm shift over childbirth - from one technicist view to another physiological phenomenon, which embraces a human experience. In this new paradigm, health professionals have their care centered on the minimum of intervention possible, respecting the physiology of childbirth, which alleviates the suffering of women[1,13].

In the research findings, unnecessary and ineffective practices were also observed in the delivery room at the time of the baby's expulsion, as shown below.

Experience of the puerpera during the phase of expulsion of labor

In this nucleus, the reports on the performance of health professionals in the delivery room and the lack of information of the parturients on the interventions were often grouped, often, unnecessarily and without the consent of the expectant mother.

The following statements illustrate the health professionals' work with theexpectant mother:

> [...] when I put my hands on my leg, he (doctor) yelled at me not to ... the doctor was more serious, rude, by the manner he spoke in the room ... he (doctor) should have been calmer, to speak more delicate ... he (doctor) was crude and rough[...] (Joan of Arc - 20 years old)

> [...] I said that I was hurting too much, and they (doctor and nurse) were talking loudly to me, and that I was going to get tired, that I was not helping, that I had to do it right to help the baby [...] I was angry at the time, because I was in pain ... I did what they asked because, I did not know what was best for me and they were already experienced [...] (Jane Austen - 22 years old)

> I told him (doctor) that I was pushing and he (doctor) said: "But with the strength you're doing, the baby is not coming", I said, "But, I am pushing" he (doctor) said: "do not scream and when it is time for the baby to come, you force yourself like to poop out" and I was pushing and nothing ... I only felt pain ... only pain ... [...] (Malala Yousafzai - 16 years old)

These statements reveal the disrespectful communication carried out by the health team, and the occurrence of inhuman care in childbirth care. According to WHO, such situations are also experienced by women in health institutions in several countries[4].

In addition, the participants mentioned some procedures that interfered in the physiology of the parturition process, causing pain and/or physical damage, without scientific basis, such as the use of the Kristeller maneuver (applying pressure with both hands on the abdomen in the upper part of the uterus, by a professional who attends childbirth) and routine episiotomy without consent, and sometimes with the intention of teaching another learner health professional[6]:

> [...] I felt that the pediatrician made a downward pressure on my belly [...] I had lost my strength, but I thought that was normal [...]. (Leonor da Aquitania - 20 years old)

> [...]during labor, he (doctor) said: "I'm going to cut", then I said, "will you cut me there" and he (doctor) said: "I already cut my dear!". (Malala Yousafzai - 16 years old)

> [...] during the "cut" I thought that the doctor spoke with irony to me because, I felt that the anesthesia was over and I asked him how many stichess he was going to do because, I think there are several layers, right! And he (doctor) answered ironically that it was going to be about 20 [...]. (Leonor da Aquitania - 20 years old)

> [...] I think he (doctor) used me to teach her (academic sudent) ... every time the baby tried to come out and did not go out, he (doctor) said "more anesthesia and a little cut" [...] I could not shout [...]. (Simone de Beauvoir - 24 years old)

The episiotomy was present in several speeches of the participants of this study. The interviewees stated that they were not informed about which procedures they would be submitted and also revealed that they did not know the reason for the procedure, besides reporting the uncomfortable senses in the postpartum period.

It is known that in the episiotomy, performed routinely in all women, the extension of the cut with anal and rectal sphincter lesion, unsatisfactory anatomical results, such as skin folds; asymmetry or excessive narrowing of the vaginal introitus; vaginal prolapse; recto-vaginal fistula and anal fistula; increased blood loss; bruises; local pain and edema; infection; dehiscence and sexual pemphinnin dysfunctionmay occur[1].

In this research, although it was not a teaching-maternity, the culture was evidenced: the non-informed and non-consented use of the episiotomy by a medical student for the training of this intervention. It is noted that these abuses are part of an institutional culture, occur with users of public and private health systems, and are not identified as a violation of women's rights[6]. On the other hand, WHO declares that these abuses are a threat to the right to life, health, physical integrity and to the non-discrimination[4].

In this sense, since 2000, the WHO has proposed changes in the child birth of hospital and medicalized births in Brazil, such as the reduction of excessively interventionist routines that brings risks to parturients, such as episiotomy, amniotomy, enema and tricotomy, and , particularly the cesarean section[2]. In 2011, the Brazilian federal government launched a program known as the Stork Network, which aims to create political, institutional and technical conditions for the implementation of changes in work processes, regarding the management qualification maternal and child care, the humanization of care, the guarantee of the rights of users and the reduction of infant and maternal mortality rates[1].

The findings of this study are in line with those of the "Nascer no Brasil" (“To be borned in Brazil”) survey, regarding unnecessary interventions during delivery, which showed that only 5% of the women interviewed had deliveries without any intervention, 91.7% were in a lithotomy position , 53.5% underwent episiotomy, 36.4% received oxytocin, 39.1% underwent amniotomy, 36.1% underwent Kristeller maneuver, and only 18.7% could be accoompained[14]. In this research, the Midwest region was identified as the region where the Kristeller maneuver, lithotomy position and episiotomy practice occur most frequently [15].

In the present study, the lithotomy position was the only one available for all interviewees to give birth, although a systematic review concluded that vertical positions reduce the duration of labor, and reduced rates of episiotomy and other interventions during labor childbirth[16].

Regarding feeding, water intake and body movements before childbirth, some interviewees stated that they were prohibited from such actions and even when they felt the urge to ingest some food or water and/or move around, they had to follow the instructions of the team because they were not instructed and therefore did not know what was going on in their bodies during the period of labor. This fact highlights the need for an prenatal care that instructs them so that they know what is beneficial, what are the unnecessary and routine procedures, thus making them act as protagonists of their deliveries.

In this perspective, care practices with pregnant women in health care institutions should be improved. The relationship between pregnant women and health professionals should be enhanced. The WHO recommends the preparation of a birth plan for each pregnant woman together with the health professional who accompanies the prenatal care. This instrument allows women to understand the practices considered beneficial and effective, in addition to knowing their rights during the parturition process, thus contributing to return the role of child birth to women[17].

An important issue observed in this study during obstetric practices was the hurry of health professionals involved in the delivery of pregnant women. This fact diminishes the autonomy of the women during the parturition process, resulting in a delivery assistance focused only on the doctor’s decision and not on the actual physiological needs of the parturient[13].

In this study, the imposition of several interventions, which is not based on scientific evidence, resulted in deliveries with painful and traumatic outcomes. This routine to which the women were subjected, was configured in obstetric violence.

It is therefore necessary to adopt preventive measures and to overcome this type of violence with all those involved in childbirth care. Although this issue is still little discussed among pregnant women, because it creates constraints on women at a time of vulnerability, obstetric violence constitutes a public health problem[6].

The scenario presented points to the questioning about the training of health professionals attending childbirth. It should be emphasized by a training centered on quaternary health prevention, that is, on the principle of minimal intervention with the aim of reducing the risks of hypermedicalization, and reducing damages and unnecessary interventions, in order to minimize iatrogenies. It is therefore the

application of the primum non nocere (first not to injury), which is one of the foundations guiding health practices[13].

FINAL CONSIDERATIONS

All the interviewees suffered some waym of obstetric violence in care during labor. The means of delivery was carried out by health professionals, with interventions and without the active participation of the parturients, making it traumatic and inhuman. This disrespectful experience of giving birth to women in their first pregnancy may lead them to believe that every normal birth is violent and that cesarean delivery is the best option.

This way, it is necessary to improve the assistance to women in parturitive process, making this process more humanized and less interventionist, in addition to the training of health professionals.

Thus, new studies on the perception of health professionals in this scenario of childbirth care are suggested, making it possible to identify gaps in the academic training of health professionals.

VIOLÊNCIA OBSTÉTRICA: EXPERIÊNCIAS DE PUÉRPERAS PRIMÍPARAS EM UMA MATERNIDADE PÚBLICA

RESUMO

O presente estudo teve como objetivo identificar situações de violência obstétrica durante o trabalho de parto. Trata-se de um estudo de caso interpretativo em que os dados foram coletados por meio de entrevista semiestruturada nos domicílios de quinze puérperas que realizaram o parto em uma maternidade pública do município sede de uma Regional de Saúde localizada no Estado de Goiás. A análise temática interpretativa foi conduzida por meio das etapas de redução, organização dos dados, identificação das unidades de significado, construção dos núcleos temáticos e interpretação dos resultados. Os resultados foram organizados em dois núcleos temáticos: experiência vivenciada durante a fase inicial do trabalho de parto e a experiência vivenciada pela puérpera durante a fase expulsiva do trabalho de parto. Observou-se através dos relatos das participantes do estudo que, durante o trabalho de parto, houve pelo menos uma forma de violência obstétrica em que a assistência foi baseada na realização de intervenções ineficazes e sem o consentimento da parturiente.

Palavras-chave: Violência contra a mulher. Trabalho de parto. Parto humanizado. Assistência perinatal. Pesquisa qualitativa.

VIOLENCIA OBSTÉTRICA: EXPERIENCIAS DE PUÉRPERAS PRIMÍPARAS EN UNA MATERNIDAD PÚBLICA

RESUMEN

El presente estudio tuvo como objetivo identificar situaciones de violencia obstétrica durante el trabajo de parto. Se trata de un estudio de casos interpretativo en que los datos fueron recolectados por medio de entrevista semiestructurada en los hogares de quince puérperas que realizaron el parto en una maternidad pública del municipio sede de una Regional de Salud ubicada en el Estado de Goiás. El análisis temático interpretativo fue conducido a través de las etapas de reducción, organización de los datos, identificación de las unidades de significado, construcción de los núcleos temáticos e interpretación de los resultados. Los resultados fueron organizados en dos núcleos temáticos: experiencia vivida durante la fase inicial del trabajo de parto y la experiencia vivida por la puérpera durante la fase expulsiva del trabajo de parto. Se observó por medio de los relatos de las participantes del estudio que, durante el trabajo de parto, hubo por lo menos una forma de violencia obstétrica en que la asistencia fue basada en la realización de intervenciones ineficaces y sin el consentimiento de la parturienta.

Palabras clave: Violencia contra la mujer. Trabajo de parto. Parto humanizado. Asistencia perinatal. Investigación cualitativa.

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