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RESEARCH
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OBSTETRIC VIOLENCE IN THE PERCEPTION OF PUERPERAL WOMEN IN A PUBLIC MATERNITY HOSPITAL IN NORTHERN BRAZIL

Violência obstétrica na percepção de puérperas em uma maternidade pública do norte do Brasil

Violencia obstétrica en la percepción de puérperas en una maternidad pública del norte de Brasil

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ABSTRACT

Objectives: to verify the occurrence of obstetric violence in a public maternity hospital in a northern Brazilian capital, from the point of view of puerperal women. **Method:** descriptive-exploratory and quantitative study, carried out with 123 postpartum women hospitalized in rooming-in. Data were collected in June and July 2020, using a structured questionnaire, analyzed in the Statistical Package for the Social Sciences®, version 21. **Results:** most were unaware (59%) but had experienced obstetric violence (74.8%). The prevalent practices were pilgrimage (34.1%), prevented from having a companion (22.8%), baby removed from the field of vision (20.3%), prohibition of food intake (18.7%), vaginal touches repetitive (17.9%), Kristeller maneuver (14.6%) and lithotomy (12.2%), occurring in the pre-delivery, delivery and postpartum sector (83.1%) and the medical category (92 .8%) involved. **Conclusion:** there was a high occurrence, inferring changes in professional conduct and restructuring of guidelines for comprehensive care for women in the pregnancy-puerperal period.

DESCRIPTORS: Violence Against Women; Obstetric Violence; Obstetrics; Nursing.

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RESUMO

Objetivos: verificar a ocorrência de violência obstétrica em uma maternidade pública de uma capital norte-brasileira, na percepção de puérperas. **Método:** estudo descritivo-exploratório e quantitativo, realizado com 123 puérperas internadas em alojamento conjunto. Os dados foram coletados em junho e julho de 2020, por meio de um questionário estruturado, analisados no Statistical Package for the Social Sciences®, versão 21. **Resultados:** a maioria desconhecia (59,3%) mas vivenciou (74,8%) a violência obstétrica. As práticas prevalentes foram peregrinação (34,1%), não ter acompanhante (22,8%), bebê retirado do campo de visão (20,3%), proibição de ingestão de alimentos (18,7%), toques vaginais repetitivos (17,9%), manobra de Kristeller (14,6%) e litotomia (12,2%), ocorridos no setor pré-parto, parto e pós parto (83,1%) e a categoria médica (92,8%) envolvida. **Conclusão:** houve alta ocorrência, inferindo mudanças na conduta profissional e reformulação de políticas para um cuidado integral à mulher no período gravídico-puerperal.

DESCRITORES: Violência Contra a Mulher; Violência Obstétrica; Obstetrícia; Enfermagem.

RESUMEN

Objetivos: verificar la ocurrencia de violencia obstétrica en una maternidad pública de una capital del norte de Brasil, desde el punto de vista de las puérperas. **Método:** estudio descriptivo-exploratorio y cuantitativo, realizado con 123 puérperas hospitalizadas en alojamiento conjunto. Los datos fueron recolectados en junio y julio de 2020, utilizando un cuestionario estructurado, analizado en el Statistical Package for the Social Sciences®, versión 21. **Resultados:** la mayoría desconocía (59%) pero había sufrido violencia obstétrica (74,8%). Las prácticas predominantes fueron la peregrinación (34,1 %), la prohibición de tener acompañante (22,8 %), la retirada del bebé del campo de visión (20,3 %), la prohibición de ingesta de alimentos (18,7 %), los toques vaginales repetitivos (17,9 %), Kristeller maniobra (14,6%) y litotomía (12,2%), ocurriendo en el sector de preparto, parto y puerperio (83,1%) y la categoría médica (92,8%) involucrada. **Conclusión:** hubo alta ocurrencia, infiriendo cambios en la conducta profesional y reestructuración de las directrices para la atención integral a la mujer en el período embarazo-puerperio.

DESCRIPTORES: Violence Contre les Femmes; Violencia Obstétrica; Obstetricia; Enfermería.

INTRODUCTION

The World Health Organization (WHO) characterizes obstetric violence as any conduct, act or omission, in a public or private environment, directly or indirectly, that subjects the appropriation under the body and the reproductive process of women, compromising their dignity, character, integrity, autonomy and freedom. It is a phenomenon that encompasses social issues, such as gender, race, class and institutional, which transforms or replaces a natural and physiological process by predominantly hierarchical, interventionist and medicalizing practices, implying the quality of life of the women who experience it.[1-2]

Among the types of violent acts, there is negligence, by omitting information to parturients; verbal and psychological violence, through shouting, threats, scolding and humiliation; physical violence, through aggression, violent procedures and non-use of anesthesia when indicated; and sexual violence, by harassment, rape or sexual abuse.[2-3]

The most frequent types of obstetric violence in health services are: pilgrimage, restriction in the choice of companion, episiotomy, abuse of medicalization, Kristeller maneuver, interference in the position and place of delivery, common vaginal touches and by different people, cesarean sections without indication, impediment of skin-to-skin contact between the woman and the newborn, among other behaviors that inferiorize and harm women.[1,3-4]

The survey "Birth in Brazil", conducted with 15,688 puerperal women, reveals that only 5% of vaginal deliveries took place without interventions and 25% were subjected to some type of aggression in the gestational process. This means that every four hours, a woman was a victim of obstetric violence in Brazil, with greater vulnerability to black women and those with low schooling, with health professionals being the perpetrators of violence.[5]

It is a difficult subject to approach, as many women feel inhibited to declare the aggressions, others still do not know their rights sufficiently to recognize, normalizing some behaviors. Therefore, it is essential to develop research such as this to produce knowledge in different locations, in order to concretely characterize the existence of the problem and highlight its magnitude and importance, thus enabling the elucidation of strategies to address it.

Thus, the objective of this study was to verify the occurrence of obstetric violence in a public maternity hospital in a North-Brazilian capital, in the perception of puerperal women.

METHOD

This is a descriptive-exploratory study, with a quantitative approach, carried out with 123 postpartum women admitted to a public maternity hospital in Manaus, Amazonas, Brazil.

The inclusion criteria were: postpartum women over 18 years of age, who had vaginal or cesarean deliveries, admitted to the maternity hospital's Joint Accommodation (ALCON). While the exclusion criteria were: postpartum women considered physically and/or emotionally unfit, who, after evaluation by the health team responsible for the sector, showed signs of pain, tiredness, irritation, nervousness, sadness, diagnosed psychopathology (puerperal dysphoria, postpartum depression and postpartum psychosis),

pathological postpartum, post-abortion situation, those with a premature newborn who needed resuscitation and those who had an out-of-hospital delivery. In order to ensure good communication and interaction, indigenous or foreign postpartum women who did not speak Brazilian Portuguese were also excluded.

Data collection took place in June and July 2020, using a structured questionnaire, prepared by the authors, based on WHO and Ministry of Health guidelines on practices considered harmful to labor and birth. The postpartum women were approached by the researcher responsible for the collection at the bedside, informed about the objectives of the research and invited to participate (respecting the ethical precepts of research with human beings according to resolution 466/2012 of the National Health Council). The questionnaire was applied twice a week, lasted an average of 20 minutes and respected the routine of the sector and the available schedules.

The study was approved by the Research Ethics Committee of the Federal University of Amazonas, under opinion No. 4.082.659/2020. All participants read and signed the Informed Consent Form (ICF) in two copies, one with them and the other with the researcher.

The data were entered and organized in the Statistical Package for the Social Sciences® version 21, which performed exploratory analysis through descriptive-analytical statistics, calculating absolute and relative frequencies, mean, standard deviation and amplitude, with presentation of the inherent results through tables.

RESULTS

A total of 123 postpartum women admitted to ALCON after their labor participated in the study. Their age ranged from 14 to 45 years (mean 25.42; standard deviation 6.34; range 31). More than half (85; 69.1%) had/lived with a partner and most (98; 79.7%) self-declared as brown. A total of 85 (69.1%) postpartum women had completed high school, 87 (70.7%) were housewives and 76 (61.8%) lived on a monthly income of up to 1 minimum wage. The majority (110; 89.4%) were from Amazonas and lived in the city of Manaus (111; 90.2%) (Table 1).

It was observed that 93 (75.6%) postpartum women had never had an abortion. Vaginal deliveries were slightly higher (62; 50.4%) than cesarean deliveries (61; 49.6%). Almost all (121; 98.4%) had a single fetus pregnancy. Although 82 (66.7%) women reported not having planned the pregnancy, 115 (93.5%) had prenatal care (Table 2).

It was found that 73 (59.3%) postpartum women were unaware of what obstetric violence was, 48 (39.1%) answered that they knew about the term and two (1.6%) did not answer.

Regarding the conducts and procedures, pilgrimage was the most pointed situation (34.1%), followed by being prevented from having a companion (28; 22.8%), baby removed from the field of vision (25; 20.3%), prohibition of food intake (23; 18.7%), vaginal touches (22; 17.9%), Kristeller maneuver (14.6%) and lithotomy (12.2%). The other questions in the questionnaire were returned with a percentage lower than 10% (Table 3).

Tabela 1- Sociodemographic profile of postpartum women (n=123). Manaus, AM, Brazil, 2020.

	n	%
Marital status		
With partner	85	69,1
Sem Without a partner	38	30,9
Race/color		
White	10	8,1
Brown	98	79,7
Black	10	8,1
Indigenous	5	4,1
Schooling		
Elementary	20	16,3
High	85	69,1
Higher	18	14,6
Occupation		
Works	27	22,0
Housewife	87	70,7
Unemployed	5	4,1
Student	3	2,4
Did not answer	1	0,8
Naturality		
Amazonas	110	89,4
Other	13	10,6
Place of residence		
Manaus	111	90,2
Countryside	12	9,8
Family income		
≤1 Minimum wage	76	61,8
2 to 3 Minimum wage	42	34,1
≥4 Minimum wage	3	2,4
Without income	2	1,6

Table 2- Obstetric condition of postpartum women (n=123). Manaus, AM, Brazil, 2020.

	n	%
History of abortion		
Yes	30	24,4
No	93	75,6
Current delivery		
Vaginal	62	50,4
Cesarean section	61	49,6
Type of current pregnancy		
Single fetus	121	98,4
Twin	1	0,8
Quadruplets	1	0,8

Planned pregnancy		
Yes	41	33,3
No	82	66,7
Did you have antenatal care?		
Yes	115	93,5
No	8	6,5

Table 3 - Types of obstetric violence pointed out by postpartum women (n=123). Manaus, AM, Brazil, 2020.

	Yes		No	
	n	%	n	%
Pilgrimage	42	34,1	81	65,9
Lack of respect from the professional	9	7,3	114	92,7
Suffered physical violence	4	3,3	119	96,7
Was reprimanded	8	6,5	115	93,5
She was prevented from having a companion during hospitalization	28	22,8	95	77,2
Your baby has been removed from your field of vision	25	20,3	98	79,7
Negligence	6	4,9	117	95,1
Experienced discrimination/social, economic and/or racial	1	0,8	122	99,2
Curettage	7	5,7	116	94,3
Prohibited from eating food during labor	23	18,7	100	81,3
Restriction of freedom of position	10	8,1	113	91,9
Lithotomy	15	12,2	108	87,8
Medication to speed up delivery	12	9,8	111	90,2
Amniotomy	8	6,5	115	93,5
Repeated and unnecessary vaginal touches	22	17,9	101	82,1
Kristeller	18	14,6	105	85,4
Episiotomy	4	3,3	119	96,7
Suture without anesthesia	1	0,8	122	99,2
Cesarean section without need/authorization	10	8,1	113	91,9
Suffered any of the above-mentioned OVs	92	74,8	31	25,2

†OV – Obstetric Violence.

According to the data, the reported cases indicated the occurrence of obstetric violence in 92 (74.8%) of the participants, while in 31 (25.2%), not.

As for the sectors of the maternity hospital in which obstetric violence occurred, the prepartum, delivery and postpartum sector (102; 83.1%), followed by the surgical center (23; 18.7%), admission (20; 16.2%) and in-hospital normal delivery center (2; 1.6%). There was no occurrence in ALCON. The uninformed data refer to cases in which postpartum women said they had not suffered violence (Table 4).

Table 4 - Sectors of the maternity hospital in which obstetric violence occurred, according to postpartum women. Manaus-AM, Brazil, 2020.

	Admission n (%)	PPP* n (%)	CC** n (%)	CPNI# n (%)	Not informed n (%)
Lack of respect from the professional	2 (1,6)	6 (4,9)			115 (93,5)
Suffered physical violence			3 (2,4)		120 (97,6)
Was reprimanded		8 (6,6)			115 (93,5)
Was prevented from having a companion during hospitalization	6 (4,9)	9 (7,4)	8 (6,5)		100 (81,3)
The baby has been removed from your field of vision		4 (3,2)	7 (5,7)		112 (91,1)
Negligence	2 (1,6)	2 (1,6)			119 (96,7)
Experienced social, economic and/or racial discrimination		1 (0,8)			122 (99,2)
Curettage		4 (3,2)			119 (96,7)
Prohibited from eating food during labor	10 (8,1)	3 (2,4)			110 (89,4)
Restriction of freedom of position		5 (4,1)		1 (0,8)	117 (95,1)
Lithotomy		14 (11,4)		1 (0,8)	109 (88,6)

Medication to speed up delivery	8 (6,6)			115 (93,5)
Amniotomy	6 (4,9)			117 (95,1)
Repetitive vaginal touches	15 (12,2)			108 (87,8)
Kristeller	6 (4,9)	5 (4,1)		112 (91,1)
Episiotomy	3 (2,4)			120 (97,6)
Suture without anesthesia	1 (0,8)			122 (99,2)
Cesarean section without need/ authorization	7 (5,7)			116 (94,3)

†PPP – Pré-Parto, Parto e Pós-Parto; ‡CC – Centro Cirúrgico; §CPNI – Centro de Parto Normal Intra-hospitalar.

Regarding the professionals identified as protagonists in the performance of violent conduct in obstetrics, the medical category was the most cited (114; 92.8%), followed by nurses (48; 39.1%) and other professionals (5; 4.1%). The uninformed data refer to cases of postpartum women who said they had not suffered violence (Table 5).

DISCUSSION

Studies in different locations in Brazil6-9 show that the sociodemographic profile of postpartum women coincides with those found in this study. It is noteworthy that the lower the age, education level and family income, especially of black (black and brown) postpartum women, the greater the propensity to experience some type of abuse during parturition.[10-11] This infers that younger postpartum women may be discredited for becoming pregnant early and, also, those with limited access to education have fewer opportunities to obtain knowledge, contributing to the occurrence of violence. Furthermore, there is no way to consider all postpartum women in an equivalent

Table 5 - Professionals responsible for obstetric violence, according to postpartum women (n=123). Manaus, AM, Brazil, 2020.

	Nurses n (%)	Doctors n (%)	Other n (%)	Not informed n (%)
Lack of respect from the professional	1 (0,8)	7 (5,7)		115 (93,5)
Suffered physical violence		2 (1,6)		121 (98,4)
Was reprimanded	4 (3,3)	2 (1,6)		117 (95,1)
Was prevented from having a companion during hospitalization	10 (8,1)	6 (4,9)	4 (3,3)	103 (83,7)
The baby has been removed from your field of vision	8 (6,6)	6 (4,9)		109 (88,6)
Negligence	3 (2,4)			120 (97,6)
Experienced discrimination/social, economic and/or racial	1 (0,8)			122 (99,2)
Curettage	1 (0,8)	6 (4,9)		116 (94,3)
Prohibited from eating food during labor	4 (3,3)	11 (8,9)		108 (87,8)
Restriction of freedom of position	4 (3,3)	4 (3,3)		115 (93,5)
Lithotomy	6 (4,9)	9 (7,3)		108 (87,8)
Medication to speed up delivery	3 (2,4)	6 (4,9)		114 (92,7)
Amniotomy	1 (0,8)	6 (4,9)		116 (94,3)

Repeated and unnecessary vaginal touches	2 (1,6)	22 (17,9)		99 (80,5)
Kristeller		15 (12,2)	1 (0,8)	107 (87,0)
Episiotomy		4 (3,3)		119 (96,7)
Suture without anesthesia		1 (0,8)		122 (99,2)
Cesarean section without need/ authorization		7 (5,7)		116 (94,3)

way, as the data imply directing specific policies to black women throughout the pregnancy period.

The proportion of vaginal and cesarean deliveries was similar in the postpartum women studied, as evidenced by other national studies.[10,12] These findings are considered negative, since the WHO points out that cesarean section rates greater than 10% do not contribute to the reduction of maternal and neonatal mortality,[13] in addition to the increase in unnecessary interventions and the increasing rate of hospitalizations corroborate the increase in the number of cesarean sections without clinical indication and the increase in public health expenditures.[10]

Studies carried out in the north and northeast of Brazil identified a high prevalence of puerperal women not knowing what obstetric violence was, nor about their sexual and reproductive rights, not being informed about the subject during prenatal care.[7,14-15] This follow-up is opportune for the user to have different clarifications, including information on obstetric violence, aiming at its prevention.[16] However, it was observed that the postpartum women in the present study were also not adequately instructed on the problem. Although almost all had prenatal care, more than half did not know what obstetric violence was, implying the victimization of the majority.

Studies conducted in Mexico, Poland and Spain also show a high prevalence of women who have experienced obstetric violence but were unable to recognize the acts. They believed that health professionals are the only holders of knowledge and therefore they knew what should or should not be done throughout the development of parturition.[17-19] This condition implies the acceptance of all imposed behaviors, nullifying the exercise of autonomy and protagonism of women.

Law No. 11,634/2007 expresses the woman's right to be linked to and to know the maternity hospital that will provide care within the scope of the Unified Health System (SUS), in order to offer maternal health services and obstetric beds, avoiding delays in care.[20] However, peregrination was the main obstetric violence evidenced among the postpartum women studied, which was no longer the main finding of other research. First pregnancy, high-risk pregnancy, gestational age below 37 weeks and low education and income are factors associated with peregrination.[21]

As in this study, about a quarter of Brazilian women are deprived and do not have their companion of free choice at some point in the parturition process.[10-12] As it is a time of greater vulnerability for women, it is essential that someone of their choice and bonding conveys comfort and security throughout their parturition.[15] This right is ensured by the companion law No. 11,108/2005,22 which is most often not complied with due to the lack of knowledge and dispossession of women, enhanced by the unequal and authoritarian relationship of professionals to them, added to the hierarchical representation of institutions.[4,23-24]

Regardless of the delivery route, the benefits of skin-to-skin contact between mother and child in the first hours of life enable bonding, stimulation of breastfeeding and physiological benefits to infants in the transition period to extrauterine life.[10] This practice was not stimulated in 20.3% of the postpartum women studied, similar to other evidence.[4,12,25]

Several hospitals in China allow and adopt measures for pregnant women to eat easily digestible food before delivery,[26] which differs from the findings of this study. The National Guidelines for Normal Childbirth Care recommend that women who are not on opioids or without imminent risk factors for general anesthesia should be encouraged to eat a light diet.[27] Considering the energy expenditure in the parturition process, ingesting liquids or food may provide better physical conditions, especially in the expulsive period. Food restriction, therefore, may advance labor, causing unnecessary interventions and sometimes resulting in cesarean delivery.[4,28]

There is no clinical justification for performing vaginal touches at intervals shorter than four hours, the period recommended by the World Health Organization.[29] However, this violent practice is perceived and experienced frequently in the national and international obstetric scenario,[8,10,15,18-19] causing embarrassment and pain to women.

A study with 1626 Brazilian women,10 showed that the Kristeller maneuver was practiced in about 14% of them, which is in line with the findings of this study. This procedure is not recommended, as it potentiates uterine rupture, anal sphincter injury, fractures in newborns or even brain damage.[27] In addition, there is no scientific evidence to prove any benefits of the maneuver, but the opposite, it can generate serious damage and collaborate to a violent birth experience.[9,14]

The obligation of the lithotomy position was prevalent in this and other investigations.[8,12,19] The favorable and comfor-

table scenario for the professional is prioritized, instead of respecting the woman's position of choice or even offering other ways of giving birth (squatting, lateral, four supports) for better comfort and safety. This reinforces a predominantly unfavorable, imposing and disrespectful context, by depriving freedom of choice and controlling the woman's body, without taking into account her wishes and needs.[25]

A study carried out in a public hospital in Pará shows that the PPP is the place of greatest concentration of violence,[2] as observed in the present study. In addition to being a large and high-flow sector in the maternity ward, it is where women spend most of their time, in constant contact with different professionals, so they may be prone to experience abuse.

Most health professionals agree with or practice obstetric violence, but do not recognize it.[23] In the case of this study, the medical profession was the most pointed out. Many use technical-scientific knowledge to justify attitudes of domination, subordination, authoritarianism, negligence and impersonality, failing to ensure the rights and wishes of women, placing them as passive beings over their own bodies. There is, then, an exploitation of the situation of women's fragility, their inability to make choices and recognize their real needs.[4,30]

Among the limits of this research, some postpartum women may not have fully expressed all the violence experienced in motherhood, either because of the new adaptations that the puerperal phase requires, or even because of the attention in the care of their newborns. In addition, it should be noted that 28 (22.8%) women reported having been prevented from having a companion, which may be related to the distancing measures recommended by the State in the COVID-19 pandemic, since data collection took place during this period.

CONCLUSION

This study found, through the perception of postpartum women, a high occurrence of obstetric violence in a public maternity hospital in northern Brazil. Even with prenatal consultations, most of them are unaware of or naturalize violent practices, favoring their underestimation. Pilgrimage, being prevented from having a companion, having their baby removed from the field of vision, prohibition of eating light food and liquids, excessive vaginal touches, Kristeller maneuver and lithotomy, represented the types of violence most experienced by postpartum women. The medical category was the one most referred to as practitioner, with the PPP sector being the place of greatest occurrence.

It is strongly recommended to create and reformulate public policies and institutional protocols, in addition to the permanent education of professionals working in obstetrics, to provide a favorable, humanized and safe environment in the labor and birth process, respecting women's autonomy. To this end, there is an urgent need to address the issue during prenatal care, through clear language from professionals to clarify sexual and reproductive rights to women, highlighting concepts, legislation, ways of how and where to report, promoting active listening and their empowerment.

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