

Obstetric violence: integrative review

Violência obstétrica: uma revisão integrativa

Violencia obstétrica: una revisión integradora

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ABSTRACT

Objective: review Brazilian researches, identifying the types of obstetric violence, possible causes observed and the role of nurses in this scenario. **Method:** integrative review realized in 2018, with Brazilian articles selected from the Virtual Health Library. **Results:** obstetric violence can be associated with: verbal and psychological offense, expropriation of the female body, deprivation of companion, lack of information, deprivation of movement, trivialization of pain, and lack of privacy. Possible causes: institutional and professional unpreparedness, authoritarianism/professional hierarchy, medicalization of care, women's socioeconomic status and education, and denial or non-recognition of obstetric violence. **Conclusion:** the obstetric nurse can contribute to the reduction of this violence. More investments are needed in the formation of these professionals and provide quality assistance in prenatal and delivery obstetric.

Descriptors: Violence against women; humanizing delivery; labor, obstetric; obstetric nursing.

RESUMO

Objetivo: revisar pesquisas brasileiras, identificando os tipos de violência obstétrica, possíveis causas observadas e o papel do enfermeiro nesse cenário. **Método:** revisão integrativa realizada em 2018, com artigos brasileiros selecionados na Biblioteca Virtual em Saúde. **Resultados:** revisados 16 artigos publicados entre 2004 e 2018. A violência obstétrica pode ser associada a: ofensa verbal e psicológica, expropriação do corpo feminino, privação de acompanhante, falta de informações, privação dos movimentos, banalização da dor e falta de privacidade. Possíveis causas: despreparo institucional e profissional, autoritarismo/hierarquização profissional, medicalização da assistência, nível socioeconômico e escolaridade das mulheres, e negação ou não reconhecimento da violência obstétrica. **Conclusão:** a enfermeira obstétrica pode contribuir para a redução dessa violência. São necessários mais investimentos na formação dessas profissionais e proporcionar assistência de qualidade no pré-natal e parto.

Descritores: Violência contra a mulher; parto humanizado; trabalho de parto; enfermagem obstétrica.

RESUMEN

Objetivo: revisar las investigaciones brasileñas, identificando los tipos de violencia obstétrica, las posibles causas observadas y el papel del enfermero en este escenario. **Método:** revisión integradora realizada en 2018, con artículos brasileños seleccionados de la Biblioteca Virtual en Salud. **Resultados:** la violencia obstétrica puede estar asociada con: ofensa verbal y psicológica, expropiación del cuerpo femenino, privación de compañero, falta de información, privación de movimiento, trivialización del dolor y falta de privacidad. Posibles causas: falta de preparación institucional y profesional, autoritarismo / jerarquía profesional, medicalización de la asistencia, nivel socioeconómico y escolaridad de las mujeres y negación o no reconocimiento de la violencia obstétrica. **Conclusión:** la enfermera obstétrica puede contribuir para la reducción de esta violencia. Se necesitan más inversiones en la formación de estas profesionales y proporcionar una asistencia de calidad en prenatal y parto.

Descriptores: Violencia contra la mujer; parto humanizado; trabajo de parto; enfermería obstétrica.

INTRODUCTION

Until the 19th century, birth attendance was considered a female attribution, performed mostly by midwives¹. However, as of the 1940s, the process of medicalization appears as a consequence of significant technological advances in medicine. From then on, childbirth begins to be seen as a pathological process, as it involves risks for women^{2,3}. In this context, the female body was considered imperfect and, therefore, unable to give birth without the aid of interventions^{3:25}.

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Thus, the childbirth process left the home environment and began to occupy the space of health institutions, where it was conducted by different actors who subjected women to different procedures in the name of science⁴. Invasive and interventional procedures were justified as they were easier and required less time⁵. However, these procedures decreased the autonomy of women and led to higher risks for mothers and babies¹. In this context, interventional procedures became routine practice⁶.

In 1996, the World Health Organization (WHO) divided these practices into four categories: practices which are useful and should be encouraged; practices with insufficient evidence to support a recommendation; practices which are harmful or ineffective and should be eliminated from childbirth care (routine intravenous infusion in labor, routine use of enema and pubic hair removal, among others); and practices which are used inappropriately, such as restriction of food and fluids during labor, liberal or routine use of episiotomy, operative delivery and repeated or frequent vaginal examinations⁶.

Therefore, interventions that can harm the physical and psychological integrity of women during care in institutions, as well as disrespect for the autonomy of women can be characterized as acts of obstetric violence^{7:1}.

In Brazil, only the state of Santa Catarina has a law on obstetric violence, describing it as “every act practiced by the physician, the hospital staff or a family member or companion in which the person verbally or physically abuses women who are pregnant, in labor or in the puerperal period”⁸. In recent years, studies have uncovered the rates of unnecessary obstetric interventions in Brazil. Data from the National Survey “Birth in Brazil” showed that only 5% of vaginal deliveries occurred without interventions and revealed that cesarean deliveries corresponded to 52% of total deliveries⁹, which goes against the WHO recommendation to keep these rates close to 15%¹⁰. In addition, 25% of women reported that they suffered some type of aggression perpetrated by health professionals during pregnancy or childbirth¹¹.

Given the existence of obstetric violence, associated with the absence of specific legislation and the high rates of unnecessary obstetric interventions, this review sought to understand the types and possible causes of obstetric violence identified in Brazilian research. It also sought to identify how the role of nurses has been portrayed in this scenario.

METHODOLOGY

This is an integrative review that sought to answer the following guiding questions: What are the types and possible causes of obstetric violence identified in Brazilian research? In addition, how has the role of nurses in relation to this public health problem been portrayed in research?

A bibliographic survey to identify the articles to answer the guiding questions of this review was carried out between May and September 2018, on the Virtual Health Library (VHL) website. The descriptors used were “Violence Against Women”, “Humanizing Delivery”, “Obstetric Labor”, “Obstetric Nursing”, “Obstetric Delivery”, “Obstetrics”, “Nurse Midwives”, “Parturition”, “Pregnant Woman”, “Pregnancy”, “Midwifery”, “Institutional Violence” and the corresponding descriptors in Portuguese and Spanish. The inclusion criteria for this review were primary studies that addressed the topic of obstetric violence in Brazil.

A total of 429 publications were found. Of these, 81 references that were not scientific articles were excluded. Of the 348 references left, 126 were excluded because they portrayed the reality of other countries, leaving 222, of which 66 were duplicates. Then, the abstracts of the 156 remaining references were read, which led to the selection of 37 studies for full reading and exclusion of 120 references, of which 62 did not address any form of violence and 58 addressed other types of violence. After the full reading of the 37 studies, 3 were excluded for not being primary studies and 18 for addressing obstetric violence indirectly.

The final critical analysis was carried out with the 16 selected studies, seeking to identify aspects related to violence against women perpetrated by health professionals in childbirth care, with emphasis on the types of violence, their possible causes and how the role of nurses has been portrayed in researches.

RESULTS AND DISCUSSION

The 16 (100%)¹²⁻²⁷ studies were published between 2004-2018 in Brazilian journals and are presented in Figure 1. It is observed that 6 studies (37.5%)^{13,16,18,20-22} were published in nursing journals, 2 (12.5%)^{15,26} in public health journals and 8 (50%)^{12,14,17,19,23-25,27} in other journals.

After reading and analyzing the studies, it was observed that, in all articles, pregnant, parturient or puerperal women or women undergoing abortion experienced obstetric violence perpetrated by health professionals and, in one specific case, by prison officers.

Titles	Year of publication
Para chegar ao Bojador, é preciso ir além da dor ¹²	2015
Violência obstétrica na visão de enfermeiras obstetras ¹³	2014
Violência institucional em maternidades públicas sob a ótica das usuárias ¹⁴	2011
Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde ¹⁵	2013
Poder, violência e dominação simbólicas nos serviços públicos de saúde ¹⁶	2004
O dilema de uma prática: experiências de aborto em uma maternidade pública de Salvador, Bahia ¹⁷	2016
Do parto institucionalizado ao parto domiciliar ¹⁸	2014
À margem da humanização? Experiências de parto de usuárias de uma maternidade pública de Porto Alegre-RS ¹⁹	2017
Percepção de enfermeiras obstétricas acerca da violência obstétrica ²⁰	2018
Parto hospitalar: experiências de mulheres da periferia de Cuiabá-MT ²¹	2006
Percepção das mulheres sobre violência obstétrica ²²	2017
Meio gogue e com as mãos amarradas: o primeiro contato com o recém-nascido segundo mulheres que passaram por uma cesárea indesejada ²³	2013
Nascer na prisão: gestação e parto atrás das grades no Brasil ²⁴	2016
Fatores associados à violência obstétrica na assistência ao parto vaginal em uma maternidade de alta complexidade em Recife, Pernambuco ²⁵	2016
Desigualdades raciais, sociodemográficas e na assistência ao pré-natal e ao parto ²⁶	2005
Percepções de doulas naturólogas sobre gestação, parto e puerpério ²⁷	2014

FIGURE 1: Articles included in the study and year of publication. Brazil, 2019.

The types of violence in childbirth identified in the articles were: verbal and psychological abuse (11 – 68.8%)^{12,14-24}; expropriation of the female body (10 – 62.5%)^{12,16,18-22,25-27}; denial of companionship (7 – 43.8%)^{12,15,17,19,22-24}; deprivation of information (8 – 50%)^{12,14,16,17,20-23}; deprivation of movement during labor and delivery (6 – 37.5%)^{17,19,21-24}; belittling of pain (3 – 18.8%)¹⁴⁻¹⁶ and lack of privacy (2 – 12.5%)^{16, 17}.

Some of the possible causes pointed out in the studies are professional and institutional unpreparedness (12 - 75%)^{12-18,20,21,23,25,26}, medicalization of care (10 – 62.5%)^{12-14,16,18-20,23,25,27}, authoritarianism/professional hierarchy (8 - 50%)^{14-16,18,19,21,23,25}, socioeconomic level and education (5 – 43.8%)^{16,19,21,25,26} and finally, the denial or non-recognition of obstetric violence (3 – 18.8%)^{14,15,20}.

Only 4 (25%) articles^{13,18,20,25} discuss the importance of the role of obstetric nurses and midwives in the delivery process, reporting that these professionals are recognized worldwide for being trained and prepared to assist women in this process.

The findings of this integrative review show that research on this topic is still incipient in Brazil, with only a small advance since 2013. This topic gained visibility in the second half of the 20th century, when it started to be studied and was included in artistic shows, documentaries, lawsuits, among others²⁸. The term obstetric violence is used to describe the types of violence perpetrated by professionals during obstetric care^{10,32}. However, the term violence is frequently not used for fear that professionals will react aggressively when faced with the accusation of violence. Thus, the term is replaced by other descriptors, such as humanization of childbirth²⁸. Other terms that are frequently used as variations are institutional violence and violence in childbirth. These variations may be related to the fact that obstetric violence is a recent concept, disseminated mainly after the mobilization around the humanization of childbirth and the publication of “Brazilian women and gender in public and private spaces” by the Perseu Abramo Foundation, which highlighted the theme of violence in childbirth¹².

Women, whether pregnant, parturient, having an abortion or in the puerperium, are frequent victims of obstetric violence. However, it is observed that the moment in which violence is more common is during the labor process. It is necessary to highlight that obstetric violence is perpetrated by different health professionals, generating reflection on the training of these professionals^{13,36}.

Types of obstetric violence

Poor service in health institutions is reported by many women as an act of violence¹⁴. In some studies, parturients reported that they were not informed about the interventions performed, which made them feel objectified, as they did not have the right to express themselves¹⁵. In addition to not explaining the procedures, many professionals did not even introduce themselves to the patient¹⁶. Some women described their labor as violent and said that employees were often aggressive and intimidating¹⁷. Among the studies analyzed, it was also found that the

lack of information makes women think that all the procedures performed are routine practices, which leads to the expropriation of the female body¹⁸. The woman stops believing in her own body and starts to believe that interventions are performed to save her life and her baby^{14,19,20}.

The types of obstetric violence reported are not limited to technical procedures, but also include the use of offensive phrases, reprimands and threats against women and their babies at the time of delivery. Changes in tone of voice and use of humiliating words, classified as verbal and psychological violence, are frequent and even consented by professionals^{20,22,33}. Use of derogatory jargon and jokes is also highlighted, for example: "When you were making it you didn't cry, why are you crying now?", "oh, don't cry, next year you'll be here again"^{15:2292}, or as in the case of a patient who was undergoing an abortion and, when examined, heard the following question: "Who wants a dead fetus?"^{17:52}. Despite the fact that several professionals disapprove of this action, the use of jargon is very common in this assistance¹⁵.

For women, the process of delivery is directly associated with pain and suffering, which are other factors associated with violence during obstetric care^{12,21,30}. Thus, keeping silence when experiencing pain is a resource constantly used by parturients trying to not experience any type of violence, since it was observed that when women express suffering, they start to be neglected by professionals¹⁴, including frequent threats of abandonment¹⁵. A lot of women experience this obstetric violence because they fear that if they complain they may be misinterpreted by the professional, which would reflect negatively on the assistance provided to them and to their baby¹⁴.

In addition to emotional support, the companion can assist in the evolution of labor and increase the feeling of control of the women, resulting in lower rates of interventions, reducing the use of analgesia and increasing the probability of spontaneous vaginal delivery^{22,30}. However, in several institutions, the presence of a companion is not yet allowed. In one of the studies in this review, the rate of presence of companions was only 3%²². Thus, denial of companionship is not only an act of obstetric violence, but also a failure to comply with law No. 11.108, known as the companion law^{22,23}.

In addition to verbal and psychological violence, physical violence is also identified in the studies, in actions such as tying down parturients during c-section^{17,23} use of restraints during labor, with the justification that the woman did not want to stay in the position that the professional requested²¹. A national survey revealed that 36% of pregnant women in prison were handcuffed during hospitalization and 8% were handcuffed during labor and delivery²⁴. With the objective of combating these actions, Law No. 13,434, enacted in April 2017, prohibited the use of handcuffs on pregnant women and parturients during obstetric care⁸.

Furthermore, pubic hair removal, restriction of food, deliberate administration of oxytocin, routine early amniotomy, use of the supine position, encouragement of direct bearing down efforts (Valsalva maneuver), Kristeller maneuver and routine episiotomy were identified as harmful practices which should be eliminated or practices that should not be supported because there is not enough evidence⁶. The performance of these procedures is a demonstration of the violence experienced by women during the process of delivery. Childbirth is a physiological event; when it is pervaded with interventions, it has physical effects on the parturient and can end up destroying dreams and expectations.³³

Possible causes for obstetric violence

Lack of preparation of institutions and professional training were the most addressed topics in the studies analyzed. Long working hours associated with lack of human and material resources are also considered possible causes for violence against patients during labor and delivery^{13,15}.

Limited knowledge on evidence-based practice can lead to the objectification of women, who are used for training interns in procedures such as episiotomy, use of forceps and even c-sections, leading to obstetric violence²⁸. This scenario has been supported by deficient training, inadequate health systems and lack of adequate supervision in these institutions¹³.

Another aspect pointed out in the studies concerns authoritarianism or professional hierarchy. This type of behavior also contributes to the expropriation of the female body and the medicalization of childbirth, since the professionals use/abuse their level of training to interfere, with behaviors that are often disrespectful and do not respect women's wishes^{19,25,35}. Parturients are subjected to behaviors that they do not understand, but believe are adequate and accept them, even if under pressure¹⁹. Many professionals do not recognize obstetric violence, and when there is a practice that is considered harmful to the patient, they deem it as necessary for the mother-child dyad^{20,34}.

The socioeconomic level was identified in the studies as a predisposing factor to obstetric violence, since black women with lower income and lower level education are easier targets for abuses such as denial of companionship and use of routine procedures^{19,26}. It was also identified that women with lower socioeconomic level and lower level education had less access to prenatal care, which contributes to the lack of information on labor and delivery²⁶.

These findings demonstrate that a change in the training of health professionals is a possible way to overcome the situation of obstetric violence. Therefore, the curriculum of undergraduate courses needs changes, so that assistance can be based on scientific evidence and critical reflection about the interventions performed^{13,33}. These findings also point to the importance of participation in congresses, up-dating courses and workshops so that professionals remain constantly up-to-date¹⁸.

In this scenario, a practice that stands out is the preparation for delivery, which must be carried out since the first prenatal consultation. This action helps women to be more informed when they reach motherhood, more prepared, both physically and psychologically, for labor and delivery, aware of their rights and duties, and imbued with knowledge about the childbirth process^{13,32}.

Importance of obstetric nursing in this scenario

Few articles addressed the importance of obstetric nursing in the context of obstetric violence. The five studies that did it highlighted the importance of this professional for reducing traumatic events in the lives of women^{13,18,20}, for the construction of a humanistic model^{20,26} and for the use of adequate practices^{16,18}.

Nursing professionals work with care and respect the physiological and natural processes of the parturient, contributing to the reduction of unnecessary interventions and to the consequent demedicalization of childbirth^{13,29,31}. In addition, it is believed that obstetric nurses can bring about great changes in relation to violent practices in childbirth care¹³, since the role of these professional is already recognized worldwide, especially because they are better trained and have the best cost-benefit in the assistance to parturients and babies⁵.

When compared to other models, the care provided by obstetric nurses presents several benefits, such as the reduction of epidural anesthesia, episiotomies and instrumental deliveries (with forceps or vacuum extractor). Their work is also associated with greater chances of spontaneous vaginal delivery, early breastfeeding and maternal satisfaction¹⁸. This professional can also contribute to reduce the number of c-sections without real medical indication and improve the indicators of maternal and perinatal morbidity and mortality³¹.

Therefore, it is necessary to strengthen the training in obstetric nursing in the country, to avoid the mere reproduction of a technical and professional-centered model that still resists and ensure compliance with the SUS principles of equity and comprehensiveness^{13,20}.

Furthermore, the construction of Normal Childbirth Centers (CPN), the promotion of home birth and a more prominent action of obstetric nurses are alternatives for changing the situation of violence in excessively interventional childbirth care^{13,15}. In the Normal Childbirth Centers, the parturient has the freedom to have a companion of her choice and a doula and can be in whichever position she wants until the baby is born. These spaces have significantly positive perinatal outcomes in relation to normal births of usual risk^{25,27}.

In addition, this type of assistance promotes the understanding of the woman's physiology and of the fact that the psychological and emotional state of the woman has a direct influence on labor. It also increases respect for the attitudes of each parturient and heightens the use of evidence-based practices, as they have a direct relationship with safety and with positive outcomes for the mother-baby dyad^{13,18}. This type of assistance has been associated with greater satisfaction of women and their families¹⁸.

Additionally, it is observed that most studies were published in nursing journals. This shows that, despite the few results obtained, the nursing area has contributed with evidence on the theme and construction of the concept of obstetric violence in the country.

CONCLUSION

This integrative review analyzed 16 studies published in Brazilian journals from 2004 to 2018 and observed they use different terminologies, such as obstetric violence, institutional violence or violence in childbirth to refer to the violence experienced by women in the pregnancy-puerperium cycle. Verbal and psychological abuse, expropriation of the female body, denial of companionship, deprivation of information, deprivation of movement, belittling of pain, and lack of privacy are some types of violence reported in the studies, demonstrating that violence in childbirth is a frequent yet underreported practice in the Brazilian scenario.

It is worth noting that professional unpreparedness, medicalization, authoritarianism/professional hierarchy and socioeconomic status of women are interconnected and synergistic factors highlighted as important causes for obstetric violence.

Changes in this scenario are associated with public policies, with emphasis on professional training, especially of obstetric nurses, whose primary role is to strengthen the humanistic model, seeking a respectful and physiological childbirth, focused on the role of women. Another important factor is an adequate prenatal care, aiming to inform and prepare women, both physically and psychologically, for labor and delivery.

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