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Obstetric violence from the perspective of women who participated in the Program "*Mulheres Mil*"

Violência obstétrica na perspectiva das egressas do Programa "*Mulheres Mil*"

Violencia obstétrica en la perspectiva de las egresadas del Programa "*Mulheres Mil*"

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The aim of this study was to verify the occurrence of obstetric violence among women who participated in the "*Mulheres Mil*" Program in a city in the countryside of Minas Gerais. This is a cross-sectional, quantitative, and qualitative case study, carried out in 2016. For quantitative variables, a descriptive analysis was performed, and for qualitative data, the thematic content analysis from Bardin was used. The survey included 20 women. The most prevalent age group was from 36 to 40 years old (40%), 40% declared to live in a stable union, and 35% said they had completed high school. There were gaps in the information that should have been provided to the pregnant women. Cesarean sections are being used as a tool to schedule the mothers, and, in addition to not knowing basic information about humanized obstetrics, participants were unaware of their rights, such as that of having a person of their choice with them as they give birth. Thus, the most effective way to combat obstetric violence is to raise awareness about this reality in the population.
Descriptors: Women; Delivery, Obstetric; Violence against women.

Este é um estudo transversal, quantitativo e qualitativo, do tipo estudo de caso, realizado em 2016, que tem como objetivo verificar a ocorrência de violência obstétrica entre as mulheres atendidas pelo Programa Mulheres Mil em um município no interior de Minas Gerais. Para as variáveis quantitativas, foi realizada uma análise descritiva dos dados, e para a análise qualitativa, utilizou-se a Análise de Conteúdo Temática a partir de Bardin. A pesquisa teve a participação de 20 mulheres. A faixa etária mais prevalente foi de 36 a 40 anos (40%), 40% das mulheres declararam viver uma união estável, e 35% afirmaram possuir ensino médio completo. Verificou-se falta de informações que deveriam ser prestadas às gestantes. A cesariana vem sendo usada como uma prática de programação da mãe, e, além de não saberem as informações básicas sobre obstetrícia humanizada, as participantes desconheciam seus direitos, como o de ter um acompanhante. Assim, a forma mais eficaz de combate à violência obstétrica é despertar a população para a existência dessa realidade.
Descritores: Mulheres; Parto obstétrico; Violência contra a mulher.

Este es un estudio transversal, cuantitativo y cualitativo, del tipo estudio de caso, realizado en 2016, que tiene como objetivo verificar la aparición de violencia obstétrica entre mujeres atendidas por el Programa Mujeres Mil en un municipio en el interior de Minas Gerais, Brasil. Para las variables cuantitativas, fue realizado un análisis descriptivo de los datos, y para el análisis cualitativo, se utilizó el Análisis de Contenido Temático a partir de Bardin. La investigación tuvo la participación de 20 mujeres. El grupo etario más prevalente fue de 36 a 40 años (40%), 40% de las mujeres declararon vivir en una unión estable, y 35% afirmaron poseer enseñanza media completa. Se verificó la falta de informaciones que deberían ser prestadas a las gestantes. La cesárea viene siendo usada como una práctica de programación de la madre y, además de no saber las informaciones básicas sobre obstetricia humanizada, las participantes desconocían sus derechos, como el de tener un acompañante. Así, la forma más eficaz de combate a la violencia obstétrica es despertar a la población para demostrar la existencia de esa realidad.
Descriptores: Mujeres; Parto obstétrico; Violencia contra la mujer.

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INTRODUCTION

With the technical-scientific development and access to resources and services, pregnancy and childbirth became the focus of studies that sought to reduce maternal and child morbidity and mortality, as well as to promote their health. This scientific evidence contributed to the increase in hospitalization during childbirth by for increasing assistance focused on medicalization. This brings forth the discussion that this structure facilitates meeting the needs of health professionals, and not necessarily those of parturients[1]. Although physiological, childbirth can be influenced by external factors, such as emotional state, environmental factors, cultural values and the background of the pregnant woman[2].

Epidemiologically, in Brazil, based on cesarean delivery rates, the increase in morbidity and mortality stands out, establishing a relationship with the current hegemonic interventionist model[3] and contradicting the initial conception of hospital births.

Brazil started actions regarding the high rates of cesarean sections, mainly to achieve one of the Millennium Development Goals, but also seeking to expand access to maternal health services in the Unified Health System (SUS) and implement humanization policies in childbirth. The strategies of the National Pact for the Reduction of Maternal and Neonatal Mortality, in consonance with the Millennium Development Goal 5, aim to reduce maternal and neonatal mortality by 75% by 2015. This resulted in several challenges for health services, even if they reduced the impact that such actions should have on improving care and reducing maternal mortality[3].

Due to this need to reduce maternal and child morbidity and mortality rates, the Ministry of Health defines as humanized birth the right that every pregnant woman has to go through at least 6 prenatal consultations, to have their place guaranteed in a hospital at the time of birth, and to have the right to a companion of their choice. In some health services this concept was amplified and started to include, in addition to the presence of a person of the choice of the pregnant women, the possibility of having music in the delivery room and the permission to spend a few minutes with the baby before he is taken to the nursery[4].

In addition to consolidating a perspective that promotes humanized childbirth, there are still many challenges that must be overcome to decrease mortality rates. Among them, the abuses committed by health professionals against pregnant women and parturients stand out, leading to a loss in the quality and effectiveness of the assistance provided, especially when considering that the preventable deaths and the dissatisfaction of women regarding assistance in childbirth take place even in well-equipped health institutions in terms of resources and use of technologies[1].

Institutional violence can be considered one of the most problematic issues today, since it is practiced by health professionals and services that should be aimed at protecting citizens. This may be one of the factors that most impact the quality of care provided in childbirth and pre-delivery and has been pointed out as one of the reasons related to preventable maternal deaths. Considering that, this is a phenomenon specifically aimed at women because it has unique manifestations, since there are traditional values and unequal power relations that permeate gender, meaning that obstetric violence can referred to as gender violence[5].

The term obstetric violence is used to group and describe the various forms of violence experienced during the childbirth process. It is possible to characterize up to 52 situations of physical, psychological, and verbal abuse, as well as unnecessary and harmful procedures[6].

The inappropriate and/or unnecessary use of technology in interventions and procedures, such as venoclysis, routine use of oxytocin, and episiotomies can be considered types of violence, since, in view of the current scientific evidence, there are interventions with potential risks and sequelae[7].

The fight against situations of violence during gestational and maternal periods and the concern for quality of care have been gaining strength within social movements. According to the World Health Organization[8], many women around the world, including Brazil, experience

situations of abuse, disrespect, mistreatment, and neglect during childbirth care in public and private health services. This represents a break in the trust between women and the health care teams and can also be a strong and negative influence in seeking and using obstetric care services. Although disrespect and abuse can take place at any time during pregnancy, during childbirth, and in the postpartum period, women are especially vulnerable.

The concept of humanized childbirth created by the Ministry of Health in 2002 included humanized care as a practice in the Ministry of Health's programs from 2006. Even with more than 10 years of humanized care programs, health workers are still unprepared, negligent, and often are responsible for malpractice in obstetrics. That includes workers from various categories, such as physicians, nurses, obstetrical nurses, or nursing assistants, generating numerous events of obstetric violence[9].

Considering the importance of violence today, especially in a context where gender issues and institutions that violate citizens' rights are prominent, a question emerges: to what types of institutional obstetric violence situations women hospitalized in maternity hospitals in Minas Gerais were submitted, and what are the aspects associated with this type of violence? Thus, the aim of this study was to verify the occurrences of obstetric violence among women who participated in the "Mulheres Mil" Program in a city in the interior of Minas Gerais

METHOD

This is an exploratory case study, with a quantitative and qualitative approach, carried out in the city of Almenara (Minas Gerais, Brazil).

Women who participated in the "*Mulheres Mil*"("Women: a thousand") Program between 2011 and 2015 were interviewed using a semi-structured questionnaire. The final number of women was decided in accordance to the principle of sample saturation. Those who met the inclusion criteria were selected until the total number of subjects was reached. Data was treated according to content analysis[10].

The inclusion criteria were: women who participated in the "Mulheres Mil" Program in the period from 2011 to 2015; had children between 2005 and 2015; puerperal women whose delivery was performed in a public or private hospital, and who were discharged, together with the newborn, before the time of the study. Priority was given to the 20 (twenty) most recent cases.

The Ministry of Education implemented the "*Mulheres Mil*" Program, initially, as a pilot project, with the objective of promoting the social and economic inclusion of women in vulnerable situations and to allow the improvement of their work potential, as well as their and their families lives[11].

Initially, it took place in 12 states in the North and Northeast regions of the country. It was idealized through a partnership with the Association of Canadian Community Colleges (ACCC), in 2007[11]. In view of the results obtained, the program was instituted nationally through Decree No. 1.015 of July 21, 2011[11]. The program is under the responsibility of the units of the Federal Network for Professional, Scientific, and Technological Education. The target audience of the "*Mulheres Mil*" Program are 16 years old or older women, heads of their family, in situations of social vulnerability, registered or in the process of registering in the single registry of SUS, with the following characteristics: in vulnerability and social risk; victims of physical, psychological, sexual, patrimonial, and moral violence; with low or obsolete educational levels; and, preferably, not yet users of the PRONATEC/BSM national program[11].

During the data collection process, participants were called, approached in person, or through printed documents. The data collection period took place from July to October 2016. A questionnaire was used that covered aspects related to prenatal care, the woman's last childbirth, the understanding of obstetric violence, the experience of childbirth, and the assistance received at the moment.

Data referring to the characterization of the participants was presented in minimum and maximum values, mean, and simple frequency. The second part of the interview script was recorded digitally, transcribed in full and analyzed using a version of the Thematic Content Analysis of Bardin's adapted by Gomes[12].

The methodological procedures that must be followed when using content analysis are categorization, inference, description, and interpretation. The order in which to analyze qualitative data is: 1st - division of the material in smaller parts (to identify the essence of what was exposed); 2nd - distribution of parts into categories (to divide extracts by similarity, into groups); 3rd - description of the content of each category (to choose the most representative speeches); 4th - inference of the results (to make inferences based on the subject's verbal and non-verbal exposures); 5th - interpretation of the results found based on the theoretical framework (to clarify perceptions, anxieties, and uncertainties, which were noted in the field diary)[12].

The research started after it was approved by the Research Ethics Committee (CEP / UFVJM), (legal opinion No. 1,639,987). The questionnaire was only applied after the Free and Informed Consent Form (TCLE) was read and signed . Each woman was informed about the purpose of the research, the method of application of the instrument and the destination of the data collected.

RESULTS

This study included 20 who had participated in the "*Mulheres Mil*" Program. Quantitative and qualitative data were obtained. The quantitative stage aimed to describe the socioeconomic and health profile related to the childbirth, and the qualitative data was used exclusively to evaluate the quality of treatments during childbirth.

The most prevalent age group was from 36 to 40 years old (40%), 40% declared to live in a stable union, and 35% claimed to have completed high school. Regarding the sources of information that women use to acquire new knowledge, most cited the internet (60%), and from the 20 women, 8 (40%) had been through two childbirths at the time of research (Table 1).

Table 1. Sociodemographic and clinical data of women participating in the "*Mulheres Mil*" Program, Almenara/MG, 2016.

Variable	N	%
Age group		
25 to 30 years	7	35
31 to 35 years	5	25
36 to 40 years	8	40
Marital status		
Single	5	25
Married	5	25
Separated	2	10
Stable Union	8	40
Educational level		
Incomplete elementary school	4	20
Complete elementary school	0	0
Incomplete high school	2	10
Complete high school	7	35
Incomplete higher education	5	25
Complete higher education	2	10
Information sources		
Printed newspaper	0	0
TV	8	40
Radio	0	0
Magazines	0	0
Internet	12	60
Others	0	0
Number of births		
1	7	35
2	8	40
3	3	15
4	1	5
5	0	0
6	1	5

DISCUSSION

Regarding the age group, the data found in this research differ from other studies, since the age group identified by them is below 35 years[13,14]. This result can be explained by the nature of the "*Mulheres Mil*" program, since it aims to train and provide tools for women to work with better quality in the job market, and thus, the demand for this program is of women already in the job market, aged over 35 years old.

According to a survey from the IBGE (the Brazilian Institute of Geography and Statistics)[15], a quarter of the population between 20 and 24 did not finish elementary school, while 22.57% of Brazilians in this age group did not finish high school — which represents 3.9 million people. According to the same IBGE survey, globalization led the internet to dominate not only the social networks, but also the sources of information.

Most women were multiparous, a result similar to that of other researches[13,14]. Among the interviewees, the total number of deliveries was 38, from which 24 were normal deliveries and 14 were cesarean sections. In many cases, what attracts the pregnant woman to a cesarean delivery is the possibility of determining the day and time of birth, as in the case of an interviewee who was able to arrive shortly before the procedure:

In the pre-delivery I didn't even had to stay there, I basically arrived and entered for the cesarean (E5).

With regards to this data, it is estimated that in 2012 the global rates of cesarean sections in Brazil were 55.6%. In public services, the prevalence is 40%, while in private ones, it is85%[16]. Other studies also point to a high number of cesarean sections[17,18]. Women who had cesarean sections have increased rates mortality, severe morbidity, ICU hospitalization, use of

antibiotics, need for transfusion, hysterectomy, and longer stays in the hospital when compared to those who had a traditional childbirth[19].

Regarding healthcare, especially in early pregnancy, Brazil has achieved an almost universal offering of public prenatal care. However, there are still inequalities in the access to adequate care. This is important, as quality care has the potential to reverse the unfavorable perinatal indicators that can still be observed in the country[14]. In this context, fifteen participants considered the assistance good, which can be considered a good index of prenatal assistance:

[...] my prenatal consultations were very good, I was attended very well in the consultations, they were on the right date and the nurse and the doctor did them. They said that I had to take a medicine that was a vitamin, and that was it (E12).

Among the remaining five, three had some complaints, and two found it very bad. Several statements stand out, some involving pain, delay, lack of proper attention, or anguish:

It was not very good, I consulted with the nurse, the doctor attended me only once and it was me who scheduled the exams. I took all the medicines they passed, which was vitamin 'E' and vaccines too (E18).

According to Portal Brasil[20], the ideal is for women to start prenatal care as soon as they discover pregnancy. In this way, the bond with the health services is build and the first exams and vaccines recommended by the Ministry of Health are prescribed. In addition, early prenatal consultations help to obtain the necessary information early, thus being able to prevent complications and risk situations. The platform highlights the fact that prenatal care can be performed free of charge by the SUS, as the system provides not only tests, but also the medication necessary for the health of the pregnant woman and her baby.

Regarding the care provided by the health team during childbirth, it is important to emphasize that each case requires its own procedures. Sometimes it is necessary to make an incision; in other cases, medication must be prescribed to control the pressure or relieve pain. These situations are considered routine, as long as the pregnant woman condition and consent are respected. In this context, this study pointed out eleven positive, four regular, and five negative opinions, in a direct relationship with the previous service (prenatal team). An example is a case in which there was a complaint about the lack of humanized preparation of nurses:

... it was very bad because the nurses are not nice they did not treat me well (E8).

The embracing of the pregnant women during the pre-delivery period requires a new attitude, according to which workers must reinforce the role of the subjects involved in the process. This embracing process includes the valorization of communication, and individualized care should be highlighted, mainly through the use of words of strength and encouragement, positive interaction, and bonding between the nursing team and the pregnant women[21].

The pre-delivery period marks the beginning of health care during childbirth and the way in which this care is conducted will influence the entire perception of the pregnant woman during the other periods. This fact was verified in this study, in which pregnant women who were well received in the pre-delivery period were more relaxed for delivery, even when there were complications. Understanding the procedures, having accurate information about what is happening and what will happen led to less anxiety in most cases.

As for the postpartum period, it can be said that it was the period with the least complaints, because with or without inconveniences before or during delivery, the postpartum stage reached its goal. In this period, women seemed to feel that being with their baby was good enough, and that they needed nothing else. Therefore, 95% of respondents recognized this period as good or regular.

Regarding the theme "obstetric violence", the focus of the research, none of the women knew the concept. Many responded the same thing, that *they did not know*, a situation also found in another survey[22]. The interviewees revealed that they are aware that this is not a good thing.

However, they did not know how to elaborate the idea, much less how to describe types of obstetric violence.

Still on this theme, only six women were able to associate possible situations of lack of care and physical aggression with cases of obstetric violence. There were also those who associated harassment or even sexual abuse with this type of violence. The research showed that 14 women had no idea what obstetric violence was and six thought they knew but had a very limited idea. However, the research found, through the history and analysis of the speeches, that among the twenty interviewees, sixteen suffered some type of obstetric violence, without knowing it.

A survey by the Perseu Abramo Foundation found that one in four women suffers obstetric violence. Many are unaware that they have suffered violence, which is defined by any unknown procedures that are performed on the patient, or even by comments made[23].

In a study, carried out in a public hospital in Catanduva, it was found that 27.9% of the participants suffered situations of obstetric violence[2]. Similarly, another study, carried out at the Maternity and Obstetric Center of a University Hospital in Santa Catarina, in 2012, identified, through interviews conducted with puerperal women, the occurrence of obstetric violence in 30% of cases[24].

In this context, the Argentinian institute Insgenar states that health professionals also lack knowledge about the rights of pregnant women and parturients, who often do not question the legitimacy of their practices[25].

The most painful moments for the interviewees were the cutting the genital area during normal delivery (episiotomy - 9%), the delivery process (contractions and expulsion time -- 39%), fear that something might go wrong or that the child would be born with a problem (30%), and post-surgery (22%). The latter was specifically mentioned by those who underwent cesarean sections.

Analyzing the most common forms of obstetric violence, disrespectful conducts and reprimands took place in 2.3% of the cases, failure to clarify doubts in 16.3%, prohibitions for women to choose someone to be there with them in 9.3%, and obstetric procedures without authorization or clarification in 27.3%. Among these, the episiotomy is the main complaint (25.5%), followed by artificial amniotomies and enemas (17% each), and, to a lesser extent, trichotomies, fasting, decubitus, stimulating medication, constant touching, Kristeller's maneuver, and cesarean sections without justification (8.5% each)[2].

The Survey[26] *Nascer no Brasil* (Being Born in Brazil), carried out in 2011 and 2012, also remarked, even more emphatically, that procedures related to labor and childbirth have been increasingly violent, with alarming and increasing numbers in the use of stimulating medication (36.4%), episiotomies (53.5%), mechanical maneuvers to accelerate birth (36.1%), cesarean sections without justification (52%), bed restriction (55.7%), fasting (74.8%), enema (91.7%) and artificial amniotomy (39.1%).

Another systematic review identified that the most cited obstetric institutional violence was negligence, especially regarding the lack of important guidance from professionals to parturients and the lack of health assistance, all of which were responsibilities of doctors and nursing professionals[27].

The maintenance of all forms of violence to which women are susceptible during childbirth makes them hostage to the fear of dying or losing their baby, and they may even be coerced into remaining silent, not denouncing the health team, which may continue to perpetuate violent actions[28].

Among the interviewees, seven felt offended/threatened due to negligence or abandonment, which ended up leaving pregnant women insecure or afraid. As the following interviewees show:

They left me a long time in the corridor, that's what I thought was bad, I got scared (E2*).*

*In the pre-delivery, they were so rude to me, the women looked at me with an annoyed face. There was a nurse in the pre-delivery who told me that when it was time to make the baby nobody screamed and left me talking alone and in pain (*E8*).*

*There was a nurse who said, why do these women need to have their children at dawn! As if we could choose when, right? (*E9*).*

*Yes, I heard from some nurses that I was too young, that I didn't shout when I made the baby, that I was dating and did not even call my mother (*E16*).*

Other studies also show the parturients' statements regarding this context, as exemplified by the following statement "*But when you did it, did you cry*?". This sentence, from a health professional, shows that the violence in healthcare begins with the concept and personal perspective according to which sexual intercourse is something filthy and that, because the parturient did it, she must suffer the pains of childbirth as a form of punishment[28].

In addition to verbal aggression, another form of violence highlighted by the research is the disrespect for the parturients' right to have a person of their choosing by their side during the procedure. One study found that out of twenty respondents, only one was informed that she had this right. In sixteen cases, women were not informed that they could have someone there, and in three cases, their right was denied, even with their request[28].

For this research there were also reports from some parturients according to which they were denied the right to have someone with them:

*[...] no, they said that I couldn't have anyone with me during delivery. I wanted either my mother-in-law or my mother to come in with me, but they wouldn't let them in (*E7*).*

Denying the right to a companion violates not only the national guidelines for humanized childbirth, but also Law 11.108/2005, which guarantees women the right to have a person of their choosing present in the delivery process. Considering this aspect, it should be noted that contact and affection, especially from family members that are important for the pregnant women, are powerful factors that can positively influence the experience of childbirth[28].

Thus, pregnant women suffer from various types of verbal and physical violence during the pregnancy process, from prenatal to postpartum. These violations include: not receiving pain relief when the hospital's routine would indicate its use and the pregnant woman consented; pregnant women not being allowed to choose the position that makes them more comfortable; rough and coarse treatment, leading to cases of humiliation and swearing towards them; prohibition or suppression of shouts and of the right of having a person of their choosing there[1]. It is also noteworthy that violence can come from the institution in a wide range of ways, due to a system that does not work as it should, or to the violence committed by professionals, when they let their sociocultural values and personal opinions influence the care provided[28].

Every woman has the right to a quality prenatal care, that aims to guarantee the health and wellbeing of her and her baby. However, there are still records of cases of maltreatment and omission, even at the time of delivery. Preventing and combating obstetric violence are important actions.

The violence to which these women are exposed begins long before childbirth. It starts in the prenatal period, which often starts late or includes fewer visits than it should, and continues until the childbirth itself, in which these women find their rights neglected by health services and/or by professionals.

Cases of violence, when practiced by the health team, usually result from relations of power. Health professionals see themselves above these women, and as a result, treat them as inferiors, mistreating them physically or verbally. In this context, the reports from these women mainly show the distance there is between them and the team, generating a lack of sufficient information on procedures and decision making that does not include the pregnant woman. Finally, there are discourses full of prejudice, mainly due to the professionals' personal values.

CONCLUSION

In this research, it was possible to identify the types of obstetric violence to which women assisted by the program suffered. An educational leaflet designed for health professionals and women attended by the SUS was prepared, so that the specific objectives of this work could be reached.

This study has as its main limitation its small sample size. However, despite being an intentional sample of a specific setting, it has the potential to contribute to the state of the art of obstetric violence research.

This research brought visibility to the problem of obstetric violence and was able to achieve its social function through the elaboration of an educational leaflet made available to the population of pregnant women, which can be disseminated to other municipalities.

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CONTRIBUTIONS

Uendel Gonçalves de Almeida contributed to the conception, design, analysis, interpretation of data and writing. **Maria da Penha Rodrigues Firmes** participated in the analysis and review. **Ana Catarina Perez** worked in the analysis and review.

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