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How precarious work conditions in health affect birth: an integrative review on obstetric violence

Como o trabalho precarizado na saúde afeta o modo de nascer: revisão integrativa sobre violência obstétrica

Cómo el trabajo precarizado en la salud afecta al modo de nacer: revisión integrativa sobre violencia obstétrica

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This study aims to conduct an integrative literature review of articles included in the LILACS platform, and to, based on a dialectic-historical method, establish a relation between the precariousness of health work relations and the high rates of obstetric violence to which pregnant women are subjected in Brazilian maternity clinics. A survey was carried out from June to August 2018, including articles which had the indexes "obstetric violence" and "precarious employment", considering the period from 2013 to 2017. Os resultados consideraram 14 artigos e, apontaram que é possível estabelecer uma relação entre a precarização do trabalho e a prática da violência obstétrica, perpassando pelos campos da categoria trabalho na concepção marxiana, a construção histórica do modelo atual de saúde no Brasil e as formas de apropriação dos profissionais da saúde no trabalho de parto e no corpo da mulher.
Descriptors: Women's health; Violence against women; Humanizing delivery; Obstetrics.

O presente estudo tem por objetivo realizar uma revisão integrativa da literatura, de artigos publicados na plataforma LILACS, e, baseando-se no método histórico dialético, estabelecer uma relação entre a precarização das relações trabalhistas na saúde e os altos índices de violência obstétrica sofrida pelas gestantes nas maternidades brasileiras. Foi feito um levantamento, realizado no período de junho a augsto de 2018, dos artigos publicados com o índice “violência obstétrica” e “trabalho precarizado”, considerando o período de 2013 a 2017. Os resultados consideraram 14 artigos e apontaram que é possível estabelecer uma relação entre a precarização do trabalho e a prática da violência obstétrica, perpassando pelos campos da categoria do trabalho na concepção marxiana, da construção histórica do modelo atual de saúde no Brasil e das formas de apropriação dos profissionais da saúde no trabalho de parto e no corpo da mulher.
Descritores: Saúde da mulher; Violência contra a mulher; Parto humanizado; Obstetrícia.

El presente estudio tiene por objetivo realizar una revisión integral de la literatura de artículos publicados en la plataforma LILACS y, basada en el método histórico dialéctico, establecer una relación entre la precarización de las relaciones laborales en la salud, con los altos índices de violencia obstétrica sufrida por las gestantes en las maternidades brasileras. Fue hecho un levantamiento realizado en el periodo de junio a augsto de 2018, de los artículos publicados con el índice “violência obstétrica” y “trabalho precarizado”, considerando el periodo de 2013 a 2017. Los resultados consideraron 14 artículos y apuntaron que es posible establecer una relación entre la precarización del trabajo y la práctica de la violencia obstétrica, permeando por los campos de la categoría trabajo en la concepción marxista, la construcción histórica del modelo actual de salud en Brasil y las formas de apropiación de los profesionales de la salud en el trabajo de parto y en el cuerpo de la mujer.
Descriptores: Salud de la mujer; Violencia contra la mujer; Parto humanizado; Obstetricia.

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INTRODUCTION

Before discussing obstetric violence[1], a term considered to be recent, within the mould that this study intends to consider, it is essential to consider certain aspects of the modes of production that structure our society, so that later we can understand how they affect the life of the parturients.

Here, we are considering the work classes according to Marxist theory, the idea according to which men, to exist, must transform nature, and that whenever they do, they transform themselves, acquiring new knowledge and abilities[2], that is, work is a process between man and Nature, a process in which men, through their actions, mediates, regulated, and controls their metabolism with regards to Nature[3].

The difference between men and animals (who also modify the nature, such as bees, which have built honeycombs that are exactly similar for centuries) is that, before execution, men idealizes the work they will execute[3]. This idealization can be called ideation, that is, one of the possible responses for a concrete necessity[2]. This idealization only surfaces when a need becomes apparent. Therefore, a man has a necessity, uses their intelligence, executes an action, and as they do so, they change nature, change their lives and the lives of those around them, which changes society as a whole due to the fact that men is a social being.

Men also have labour power, physical and mental capabilities for work. They ideate an action, and later execute it, using this power. The labour power is the most essential element of men[2].

Men externalizes their labour power through work, they employ their attributes and recognize themselves in the work they created. The final product they create acquires a use value, because it was created to attend a previous need. The means of production take place when the use value enters, once again, in a process of work.

The working process changes throughout the years. Today, the so-called abstract labour (while concrete labour is related to the physical qualities of an object)[3] is related to the human energy spent to perform a work (and not to the work as a category that originates the social being). Men, from the moment they start selling their labour power to survive, start working for the capitalist system, producing goods and generating surplus value for the self-valuing of capital[2,3].

Since workers start working for their employers, in favor of the capital (selling their labour power and generating surplus value), the employer will try at all costs to avoid waste, optimize time, and suck out all the labour force possible out of the workers, since the more explored he is, the more profit the employer will make.

This situation of paid workforce exploration means that the worker is a subordinate of the employer. Today, society is in such a stage that, to survive and provide for their basic needs, people have as their only option the selling of their labor power for a salary. They become employees, in addition to being expropriated, alienated, that is, unconnected to what they are producing, incapable of recognizing themselves in their final product[2].

Human needs may be divided in basic needs and intermediary needs. Basic human needs are objective and universal categories, that should be satisfied simultaneously: physical health and autonomy[4]. In this process, the needs of human workers are not considered.

The work of an alienated worker who receives a salary removes the autonomy of the worker, since the capital creates market needs to the detriment of human needs.

When one considers this in regards to the health field, it can be noted that workers in this context also sell their labour power for a salary. These workers have feelings, expectations, desires, plans, and oftentimes lose motivation due to their low salaries and to the lack of recognition for their works, and to having to work in more than one place due to the low salaries[5], which leads to work overload, which is associated to inadequate infrastructure, and lack of preparation and motivation[5].

On the other side of this relation are pregnant patients, women in a delicate moment of their lives - that of childbirth. In this situation, these women need attention, requiring a human touch: a look, a word, attentive listening, embracing, so that they can become stronger in their own humanity[6].

Therefore, in this contradictory work process, many health professionals, physicians, nurses, nursing technicians, social workers, psychologists, nutritionists, among many others, act and live through the expressions of the capital in their daily lives, as they offer direct care to pregnant women.

An adequate follow-up by the medical team during childbirth brings benefits to the evolution of natural delivery, which in turn brings benefits to the health of mother and child. However, obstetric violence is a real problem. Many researches were conducted in the field, quantifying, disseminating, and elaborating a concept of the issue.

Government entities and the World Health Organization (WHO) recognize this problem and have published dossiers, guidance, and booklets, to instruct both pregnant women

and medical teams so that obstetric violence is avoided. However, this type of violence has not become less frequent during the years[5].

Reflecting on the reasons that lead to obstetric violence is unavoidable. This study aims to trace a connection between the professionals (who take this violent action) and the pregnant women (victims), taking into account the precarious work situations. Health professionals are inside the work market logic, increasingly expropriated and alienated, and are not in fact capable of offering the attention and the good practices that the WHO recommends. They are not trained, instructed, and do not have the time neither receive encouragement from the management of the hospitals.

This study aims to conduct an integrative literature review of articles included in the LILACS platform, and to, based on a dialectic-historical method, establish a relation between the precariousness of health work relations and the high rates of obstetric violence to which pregnant women are subjected in Brazilian maternity clinics.

METHOD

This is an integrative literature review about scientific material found in the LILACS database from June to August 2018, using the descriptor "obstetric violence". The Marxist theory was the theoretical basis of this work.

At first, a survey was carried out using the descriptor, and later, the productions from 2013 to 2017 were considered. The articles found were read, analyzed, and described, specifying author/year of publication, title, objective, methodology, and results. International productions were excluded, as well as those who did not fit the theme and those whose full text was not available online.

In another search in the same database within the same period, the descriptor "Poor work conditions", to try and related the theme with obstetric violence.

RESULTS

At first, 60 documents were located, among which there were 52 scientific articles, six theses, one monograph, and one project document, dated from 1999 to 2018. As works from outside of the period analyzed were eliminated, 42 were left. Among them, 13 were discarded because they were unrelated to Brazil, and one of them did not had its full text available online, making it impossible to read it. From the 28 documents left, 15 did not discuss obstetric violence from an institutional perspective, leaving 13 documents left, plus one that was targeted at discussions on poor work conditions, and these were included in the research.

Among the articles, 2 discussed obstetric violence from the perspective of the professionals (*), 7 from the perspective of women in their puerperium (**), and 5 were literature reviews on the theme (***), according to Table 1.

Table 1. Articles about institutional obstetric violence, from January 2013 to 2017. São Paulo, June to August, 2018.

Author (Year)	Title	Objective	Methodology	Results
Aguiar[7] (2013) From the perspective of professionals*	Violência institucional, autoridade médica e o poder nas maternidades sob a ótica dos profissionais de saúde	Discussing institutional violence from the perspective of professionals	21 women in their puerperium and 18 health professionals (10 obstetricians, 5 nurses, and 3 nursing technicians) were interviewed in a hospital in São Paulo using a semi-structured script.	Professionals recognized there were discriminatory and disrespectful practices in the daily attention offered to pregnant women. These are practices understood to be violent, but that are trivialized, treated as if they were good.
Leal[8] (2018) From the perspective of professionals*	Percepção de enfermeiras obstétricas acerca da violência obstétrica	Getting to know the perception of obstetric nurses about obstetric violences in an Obstetric Health Center in Belém, Pará.	Data was collected in semi-structured interviews, carried out with 19 obstetric nurses, from April to May 2016.	The obstetric nurses notice that violence presents itself in many different ways. However, they do not see certain practices as violence. The study found that preventive strategies are necessary to avoid obstetric violence.
Rodrigues[9] (2016) From the perspective of the women**	Violência obstétrica no processo de parturição em maternidades vinculadas à Rede Cegonha	Analyzing the institutional violence against women in the process of childbirth in Cegonha Network maternities in Fortaleza and Cascavel	Descriptive and quantitative study, carried out in 11 hospital-maternities with 3,765 women in the puerperium, from November 2013 to January 2014.	The research shows the importance of offer adequate humanized care through structuring and organizing mother-child attention as proposed by the cegonha network.

Andrade[10] (2016) From the perspective of the women**	Fatores associados à violência obstétrica na assistência ao parto vaginal em uma maternidade de alta complexidade em Recife, Pernambuco	Analyzing factors associated to obstetric violence and the practices that are not recommended by the WHO, from the perspective of women in the puerperium	Cross-sectional study with 603 women in the puerperium from August to December 2014.	86.57% of women attended had been victims of obstetric violence
Pedroso[11] (2017) From the perspective of the women**	À margem da humanização? Labor experience of users in a public maternity in Porto Alegre/RS	Knowing about the experiences of women regarding labor assistance.	Qualitative exploratory research, using participating observation techniques, semi-structured interviews, and document research, involving 25 women from 18 to 38 y/o who were in their puerperium	A fragmentation of practices understood as "humanizing" was found. The overestimation of intervention technologies/practices in women's body, hierarchies between professionals and users, emphasizing reproductive hierarchies and leaving women at the margins of humanization
Sena[12] (2017) From the perspective of the women**	Violência obstétrica no Brasil e o ciberativismo de mulheres mães: relato de duas experiências	Relating the efforts against obstetric violence in Brazil to women's cyberactivism, especially when these women are mothers	An experience report with two initiatives taking place from 2012 to 2013	These initiatives culminated on the production of a documentary called "Obstetric violence - the voice of Brazilian women", that contributed for mobilizations, debates, and reflexions towards increasing the visibility of the obstetric violence problem. These actions incentivate the use of the internet as a strategy to promote new researches and women's health and empowerment, as well as their participation in politics.
Castro[13] (2018) From the perspective of the women**	Narrativas sobre parto domiciliar planejado após parto hospitalar	To know the narratives of women who had planned home births, with a previous history of hospital delivery	Qualitative investigation, with the adoption of a theoretical-constructivist perspective, achieved through the observations of support group meetings in semi-structured interviews with 4 women in the city of São Paulo	It allowed to notice that the vulnerability of women in the hospital, the repercussions of separating the child from the mother too early. Regarding home childbirth, it involved information and affirmation of the autonomy of the women, as well as their body perception during labor.
Rodrigues[14] (2015) From the perspective of the women**	A peregrinação no período reprodutivo: uma violência no campo obstétrico	Analyzing women's perception on the obstetric assistance when it comes to childbirth when discussing childbirth attention in the Metropolitan II region in Rio de Janeiro	Descriptive, exploratory, qualitative study, carried out in joint accommodations of 4 public maternities, involving 56 participants	The ambulation of women in their puerperium is seen as obstetric violence. A permanent obstetric assistance evaluation was understood to be important, including policies targeted at humanization
Souza[5] (2016) Literature review***	Fatores associados à ocorrência de violência obstétrica institucional: uma revisão integrativa da literatura	Integrative literature review on the factors associated to obstetric violence	Data acquired through a selection in the databases Lilacs, MedLine, Scielo, and Google Scholar, made up of 20 articles published from 2010 and 2016.	It was found that the professionals described as those who promote violence were physicians, the nursing staff, and medicine students.

Diniz[1] (2014) Literature review***	Violência Obstétrica como questão para a saúde pública no Brasil: origens, definições, tipologia, impactos sobre a saúde materna, e propostas para sua prevenção	Discussing the complex causes of violence, the role of professional formation, the organization of health services, and the implications in maternal morbidity and mortality	Critical-narrative review on the subject, involving academic literature, the production of social movements, and institutional documents in Brazil and abroad	The research indicates that changes need to take place in the formation of those who are the human resources of the institutions during graduation and specialization, specially among physicians, with the use of more up-to-date bibliographies. Disseminating information on childbirth assistance, guaranteeing the right to a companion, fomenting researches in the field, and including the assistance to safe abortions
Tesser[15] (2015) Literature review***	Violência Obstétrica e prevenção quaternária: o que é e o que fazer	Justifying the need for quaternary prevention when confronted with obstetric violence	Original article that does not specify its methodology	Presents three actions as a proposition: 1) elaboration of guided childbirth plans; 2) the introduction of other qualified professionals in labor care; and 3) the participation of Family and Community Physicians (FCP) and PHC professionals in the social and political movement for labor humanization
Zanardo[16] (2017) Literature review***	Violência obstétrica no Brasil: uma revisão narrativa	Performing a narrative review of studies on obstetric violence	Article that does not specify its methodology	Data suggest the need for a legally binding concept of obstetric violence, documents that define and criminalize the practice
Barbosa[17] (2017) Literature review***	Violência obstétrica: revisão integrativa de pesquisas qualitativas	Performing the integrative review of qualitative researches	From the chosen bases, 17051 articles were found. After applying the criteria, 54 were left	Labor assistance practices in Brazil disrespect sexual and reproductive rights of women, reflecting on the high rates of unnecessary cesarean sections and on the mistreatments women suffered in Brazilian maternities

Regarding the term "Poor work conditions", 13 works were found. From these, 10 were scientific articles and three were theses. Only one discussed poor work conditions in health. That means that, despite dating from 2011, it was selected to be read, since it was the only work found on the theme (Table 2).

Table 2. Articles on poor work conditions 2011. São Paulo, June to August, 2018.

Author (Year)	Title	Objective	Methodology	Results
Silva[18] 2011	Vivências de trabalhadores em contexto de precarização: um estudo de caso em serviços de emergência de hospital universitário	Presenting the daily lives of emergency workers of the University Hospital Antônio Pedro in Niterói/RJ	Analyzing labor experiences with nursing and social service professionals, highlighting their experiences through the analysis built by the Broadened Research Community. A group with 10 workers, monthly 2 hour meetings from April to September 2011	It proved to be very difficult to build an environment that was conducive to pleasure and to the professional realization of experiences, due to the current policies aimed at dismantling the sector, in addition to temporary hires and precarious environments. These difficulties led to psychic suffering at work in a pathogenic dimension

DISCUSSION

According to the documents surveyed, obstetric violence is practiced throughout the entire country[12,17], and oftentimes is disguised as a good practice[5,7,11]. This happens as a result of the lack of understanding of both the medical team and the parturients about the actions that are considered obstetric violence[1,8,14,16].

Even though obstetric violence is a new term [17], there are many articles that discuss the subject, which is well-organized in its concepts, categorizations, and definitions of what is or is not violence[1,5,7-12,14,16].

The results of the research suggest that an urgent humanizing practice is required from the moment of childbirth on. However, the difficulties are manifold, since the structure of the health system, based on the current models of a capitalist society, seeks profit to the

detriment of social wellbeing, and is not favorable to the necessary changes[8,9,12,15].

Current labour relations, with poor work conditions, worker alienation, workers' rights expropriation, temporary jobs, lack of formation and training, creates a pathogenic environment. The workers become sick and more vulnerable and likely to practice acts of violence due to their lack of knowledge on what constitutes said violence, in addition to factors such as fatigue and lack of encouragement. In a precarious social context, the meaning and importance of work disappear[18].

There was an absence of articles that relate poor work conditions to the practice of obstetric violence, a situation that may be explained by the trivialization of violence.

Health in Brazil is currently guided by a model focused on hospitals[14], cures, and diseases. The process of work in health is fragmented and hierarchic as medical specialties proliferate, offering opposition to actions that incorporate intersectoral articulation, interdisciplinary approaches, and social participation.

Before the current model, public health in Brazil covered a long way and followed many models. In the beginning of the nineteenth century, there was a biomedical model, which associated disease to lesion with a narrow perspective regarding health and disease, and disregarding socio-historical dimensions[19].

In 1923 the Carlos Chagas Reform took place. The health model of the time was a private social security, under the influence of liberal medicine. It offered medical/hospital assistance to urban and industrial workers through health insurances. This was a model that followed austerity guidelines[19].

At the end of the last century, the model changed to a preventive one. It expanded the micro-biological paradigm of disease to the population, aiming to organize and sanitize people and public and private spaces. This model was predominant up to the decade 1960[19].

However, in the context of the fight against dictatorship, the Sanitary Reform movement started in the beginnings of 1970. The expression was used to refer to the group of ideas that existed, related to the necessary changes and transformations in the field of health. These changes did not include only the system, but the entire health field, seeking to improve the conditions of life of the population[19].

The 1988 Federal Constitution states, in its 6th article, that health is a social right, while article 196 states that it should be guaranteed by the state through public policies. The Constitution brought to life the Unified Health System, SUS[19].

In 2018, SUS completed 30 years of existence. It is presence in 100% of the national territory. Data[20] confirm that the health model in Brazil is focused around hospitals, showing that 67.6% of people seek SUS to treat diseases, while 27.9% seek them for prevention. Prenatal care is a part of this number. According to the same research, 66.8% of the Brazilian population is female. Black and brown people are the majority, 56%, and 66.5% are between 15 and 59 years of age. From this population, 88.8% do not have private health insurance.

In the logic of capitalist, health throughout the world is increasingly suffering the influence of the private sector. As the offer of private health services grow, and despite the fact that the SUS is firmly stated as a policy and that the Constitution guarantees that everyone must have access to health, the services being offered by the system are undeniably falling apart, and there is a tendency for SUS to cease being universal.

Publications on the theme [16-21] show that up to the end of the XVIII century, childbirth was a natural and common ritual in the lives of women. It used to be conducted in the house of the pregnant woman, together with midwives and other women from family and community. At the end of the XIX century, attempts from the field of obstetrics to control this biological process started to change this process, which stopped being a part of the female universe and started being seen as a medical practice[22].

With the implantation of medicine schools in the 19th century Empire of Brazil, the medical corporations make an effort to make the obstetric physician look pleasant, so that women trust them, while, at the same time, it was said at the time that women were the weaker sex, that they were sensible, passive, tender, and delicate. In this period, the "myth of maternal love" was established, as well as that of the "dedicated mother, good wife, and woman of the house"[21], a myth that is still current, and in Brazil has been recently recalled by a journalistic piece published in the magazine Veja in 2016, which complimented the then future first-lady of the country with the title: "Beautiful, discrete, and home-bound".

Considering this, it is easy to notice the relation between the historical construction of weakness in the female figure and the ways in which medicine has taken advantage of that through the childbirth process, as it has taken control over the body of women and led them to give birth in hospitals, despite the poor conditions. The introduction of medicine in this space brought in its wake not only clinical experimentation articulated to an anatomic-pathologic discourse, as it also produced a discourse that allowed for the penetration of the masculine figure in the obstetric practice and knowledge[21]. Being born within a

maternity became something common, that most women no longer question.

Being born in a hospital is nonsensical, since in the hospital-focused model in Brazil, there is a great number of diseased people in hospitals, undergoing many types of diseases, and being born is health, is life. The maternity ward of a hospital can oftentimes offer more risks than benefits to parturients and their newborns, including contaminations and infections.

Women, as they stop being the protagonist of their own childbirth (as they incorporate the ideas in the discourse that says they are weak) becomes a supporting actor in a process whose main actors are the obstetric physician and his medical team. They become the object upon which obstetric violence can be inflicted, which means that introducing medicine in this space not only brought the clinical experimentation articulated to a anatomic-pathologic discourse, as it also produced new ways of understanding that stem from the penetration of the male figure in the obstetric knowledge and practice[21].

In addition to the inherent risks of the hospital environment, alarming data was divulged in 2010[6] about obstetric violence, according to which 25% of parturients have been victims of obstetric violence by health professionals.

It is possible to understand that in Brazil the concept of violence has been used to describe and group many different types of violence (and damage) during professional obstetric care. That includes physical, psychological, and verbal abuse, as well as unnecessary and/or harmful procedures[15], that is, obstetric violence is the unnecessary manipulation and exposure of a woman's body, as well as a violation of their rights, including their loss of autonomy and of the power of deciding about their own bodies.

As soon as women incarnate the image of weak that results from a perspective that was built when Brazil was still an Empire and has been exhaustively reiterated until contemporary times, they abandon the power of making the decisions about their bodies and start accepting the orders of the physicians, believing that their decisions are the best option for that moment, that medicine is efficient in this process. Oftentimes parturients do not know they are being the victims of obstetric violence.

A research indicated that labor has been overmedicated, using to a large extent procedures that are considered to be inadequate and unnecessary[22], that put the lives of woman and child at risk, since it has been proved that these interventions are not based on scientific evidence.

With regards to the attention offered in the moment of childbirth, there are, currently, three models[6]. A highly medicated model with low participation of obstetric nurses or midwives, and is used in the United States, Ireland, Russia, Czech Republic, France, Belgium, and urban regions of Brazil; a humanized model with higher participation of obstetric nurses or midwives and less interventions, found in the Netherlands, New Zealand, and Scandinavian countries; and mixed models, found in countries such as Great Britain, Canada, Germany, Japan, and Australia.

The Federal Senate published in 2012 a dossier called "Obstetric Violence - You Will Give Birth Through Pain[24]", elaborated by the Network Parto do Princípio, to the Mixed Parlamentary Commission for Inquiries (CPMI) of Violence against Women. In this document, the most common types of violence that take place in Brazilian maternities are found[24]:

a) Episiotomy - this is a cut in the perineum with scalpel or scissors, routinely conducted and with no scientific evidence indicating its efficiency. In most cases, it is carried out with no anesthetics and no consent from the patient. As serious as episiotomy is the suture called "the husband's suture", which aims to keep the vagina very tight, so that male pleasure in sexual intercourse after the childbirth is "preserved";

b) Interventions to verify and accelerate birth - routine use of synthetic oxytocin (a synthetic hormone that accelerates labor, causing terrible pain and making patients beg for a c-section); artificial rupture of the bag; manual cervix dilation to fasten dilation; followed by commands to push; forceps and the use of the Kristeller maneuver, in which a person from the medical staff, using both hands, or standing on top of the woman, squeezing their womb with the weight of the body on the hands, arms, forearms, or knee, pushes the belly of the woman towards the pelvis and forces birth;

c) Fasting, including that of water - this practice has no scientific bases and its only use is making the woman tired and dehydrated;

d) Position restrictions for birth - there are practices according to which women must give birth laying down. The guidelines of the WHO and of the National Sanitary Vigilance Agency (ANVISA) states that the woman should be free to choose the position in which they feel the most comfort;

e) Disrespectful acts and exposure of the body - in many maternities, women are together, with no dividing walls; the touch exams to verify dilations are carried out with no privacy at all as a routine;

f) Psychological violence - understood as neglect, abandonment, contempt, humiliation, threats, coercion, prejudice, discrimination due

to race, ethnicity, social class, homophobia, harassment, sadism, blaming, and blackmail;
g) Physical violence;
h) Sexual violence.

A study from 2014, a research called Social inequalities and the satisfaction of women with labor attention in Brazil: national hospital study[24], which interviewed the considerable number of 23.523 Brazilian parturient women, reached very interesting conclusions:
- the first is that, the higher the education of the parturient woman, the more respect they receive from health professionals, the more privacy in exams, and the more explanations were given clearly to them;
- the second is that in private hospitals there were less reports of obstetric violence and a higher degree of satisfaction, in addition to a better relationship with professionals, which indicates that the principle of equality in healthcare is not being maintained.

This data can be interpreted by the fact that women who undergo prenatal care in the private network generally develop a bond with their obstetrician, and at the moment of birth, they are more confident. The SUS healthcare model does not guarantee that a pregnant woman will always be attended by the same physician, and it is even less likely that the same physician will be attending her labor.

Another finding of this research is related to the anatomy of the parturient. It was found that, in the public network, there is a discriminatory culture that sees women of low income and educational levels as incapable of making decisions about interventions at the time of childbirth. That explains the reasons for the first conclusion showed above, that they receive less clear explanations, i.e., the team does not listen or talk to these women[24].

The obstetric violence setting is naturalized in the minds of both professionals and women. A study[7] carried out by the Medicine School of the Universidade de São Paulo interviewed 18 health professionals and found that the trivialization of institutional [obstetric] violence is disguised as good professional practice and as a putatively legitimate exercise of authority, which is evidenced by the responses of the interviewees, who did not recognize the practices of violence as violent acts.

Another current practice in maternities is the immoderate number of cesarean childbirths. The rates in Brazil have been very high for decades. Decades indicate that in 2012 85% of labors in private practice were c-sections[25].

Cesarean sections are effective interventions to save the lives of mothers and child, but only when indicated by medical reasons. Before this procedure existed, many women would die during labor due to complications. That is why the WHO considered that between 10 and 15% of women need to undergo the procedure[26], as to guarantee the survival of mother and newborn.

Among the potential risks of the surgery, is premature birth. Prematurity is a known determinant of child mortality. Babies born between 37 and 38 weeks of pregnancy, when compared to 39 to 40 week babies, are 120 times more likely to need mechanical ventilation. In addition to complications with the babies, the mothers are also exposed to several risks, since this is a medium-sized surgery. There are risks such as hemorrhage, complications, and infections[27].

There is a culture of cesarean sections among the Brazilian physicians, as a research indicated[27], showing that 75.6% of women, when interviewed, stated that they do not want c-sections, claiming, among other reasons, that the post-op is too complicated and painful. This shows that the woman is not the main actor of the childbirth, since most women who undergo c-sections did not ask for them. Concurrently, 19% of those who underwent natural childbirth claimed to have asked for a c-section. This shows the limited power women have in determining the type of labor they will undergo, be it vaginal or cesarean.

The same research[27] showed that, during natural childbirth, many women who had been hospitalized from a long time - from 6 to 12 hours - required the c-section. That was due to the fact that the maternity did not abide by the good practice rules that should be adopted. As the minimal conditions and simple practices that offer comfort and wellbeing to the woman were not fulfilled, the stay in the maternity and the labor is a process of suffering, and the cesarean sections become an option that will offer a swift end to that suffering.

A research indicated that the groups of activists that fight for labor humanization[12] were started by women who were dissatisfied (perhaps after being the victims of violence) and by professionals who had trouble in offering a more humanized care. With the advent of internet in the 1990s, these movements have been gaining force in Brazil and in the world. A quick search engine research offers an easy and quick glimpse to the numerous groups and Non-Governmental Organizations (NGOs) that defend the practice of humanized birth[12].

Currently, groups fighting for health care humanization have emerged, especially associated to labor humanization. As these movements emerge, it is impossible not to think that these movements would only appear if something was becoming de-humanized. Considering the historical context, it is easy to see that when women gave birth in their

houses, there was no violence. The environment was familiar and welcoming, women involved in labor offered and exchanged help.

A research indicated that humanization demands a profound transformation of the assistance model, of the relation between the health professionals and pregnant women[11], as to create a more horizontal relation between physician and patient and help women secure their leading role in the process, since the current childbirth model in Brazil has been reproducing institutional violence, and reiterating the stigma according to which women are frail, and labor, a moment of great suffering.

Poor work conditions have been increasingly trending in Brazil, through workforce outsourcing. Currently, after the 2016 reform of labor laws, outsourcing is not only permitted in activities indirectly associated to the objective of institutions, but also for the main activities performed there. That means that work processes will be increasingly poor and alienating, since outsourcing defers the responsibility of a "first party" - who should be responsible for the work relations - to a "third party", thus freeing big business from paying taxes and attending the rights of the worker[7].

Under the guise of partnership and cooperation, weakened work relations affect social relations and society as a whole, leading to the social alienation of work. The work is no longer the founding category of social beings, because in this society, human relations go through a process of objectification. A consumerist, de-unifying, and exacerbated individualism emerges. Individuals become more and more lonely, losing their values and the notion of belonging to the human species[7].

It is important to think of the possible reasons that drove society towards away from seeing work as the founding category of the social being. Studies[7] indicate three possibilities: 1) Work and sickness as a public health problem; 2) Work and degradation, devastating natural reserves; 3) Work and social precariousness, compromising entire generations, and depriving them from education and dignified work, generating social violence.

Society is so well-developed technologically speaking, that it could live in harmony with nature and people with one another, if it was not the world of continuous production, especially structured and moving via the accumulation of capital and profit[7]. As a result, it can be stated that the way in which society operates leads individuals to be expropriated from their dignity and alienated from this process.

The relations established between the current work conditions and health professionals are strict and correlated, since they are inserted in this marketplace logic. Through the research, it was possible to find that the obstetricians work from 40 to 60 hours a day, and the nurses work from 40 to 72 hours a day. The demand burden, the structural conditions, and the low material resources were pointed out as the difficulties faced daily by the professionals[18].

In addition, may professionals work on duty, 24 hours straight. That contradicts their biological rhythm, favoring diseases to overcome them and the occurrence of medical mistakes and accidents[7].

In these conditions, a parallel can be established between the increasingly acute presence of capital in social relations and, at first, the current hospital-centered healthcare model meant women lost their autonomy and the main role they should have at birth, favoring excessive medication and interventions, in a hierarchy in which medical authority reigns supreme. The same parallel applies to the transformation of health professionals in agents of violence due to their own poor conditions of workers inserted in a marketplace logic of work, leading not only to physical and emotional exhaustion, but also to difficulties in reflecting on their practices[7].

Health, understood in its broader sense, as indicated by the 8th National Conference about Health[28], is not only the absence of disease, but also the result of adequate conditions for having a good diet, a place to live, education, transport, work, leisure, freedom, access and ownership of land, access to health services. Health also comes as a result of the forms in which production is organized in society, which can lead to inequalities in levels of quality of life.

In this case there are two contrary sides. If, on one hand, health (in the broader sense of the word) is the primary need of men, on the other, the structure of capital removes from workers this premise of life, health itself, through production models that explore the workforce.

From this perspective, the professionals involved in the health field (a complex field, requiring many types of knowledge, experience, and information) need to expand their look to beyond the appearances, so that health is understood as a social production.

There is a group of factors that influence the way in which people come to the world nowadays. The medication of childbirth (which was a complex socio-cultural process that transformed something that was previously common and inherent to women in a medical need, filled with suffering, pain, loss of women's capability of dealing with the phenomenon of childbirth, issues that used to be managed in the family and community environment as natural),

associated to the poor work conditions of health, and to the devaluing of women, in the sense of keeping them in a supporting role during the childbirth process, have, as a result, obstetric violence.

Capitalism influences even the way in which we are born, through the application of inhumane process, permeated by violence. However, how can the workers act humanely when they often live so precarious lives themselves?

CONCLUSION

The limitations of this study are connected to the fact that only one database was researched, in a restricted period. However, the review presented 14 productions directed at the precarious nature of work relations in health and to the obstetric violence undergone by pregnant women in Brazilian maternities, highlighting the way the interests of capital strongly affect the way in which we are born into the world.

Since Brazil was an Empire, there has been a patriarchal culture of considering the woman as the weak gender, of planting the idea that they cannot have children naturally. Throu the use of cesarean sections, doctors organize their schedules better, and as a result there is an extremely high level of unnecessary c-sections, as shown by the researches mentioned.

However, to eradicate obstetric violence, diminishing the high levels of unnecessary c-sections while improving the life and work conditions of health professionals, public policies are not enough. The childbirth healthcare model must undergo comprehensive changes. Hospitals need to adequate their physical structures, hire professional - especially midwives, obstetric nurses, and doulas (women who offer physical and emotional support to the parturient women), resorting to physicians and nurses only when there is a real need for intervention, since it can be seen that violence is a result of the precarious nature of the Brazilian health system itself.

Additionally, it is necessary to discuss the issue of humanization in medical care during the academic formation of the medicine student, something that should be a part of the mandatory syllabus, in addition to a continued training for health professionals.

Also, all these measures are seen as palliative in the objective of diminishing the absurdly high rates of 25% of women being victimized by obstetric violence, since the research pointed out that there is a strict relation between the practice of obstetric violence and the poor conditions to which health professionals are submitted.

Therefore, through this research, it was possible to find that there is a direct relation between obstetric violence and the already extrapolated limits of capital, a capital that extirpates even minimal survival and humane conditions from the workers, removing from them the ability to see human suffering in others, trivializing and naturalizing violence, and making it so people do not become indignant when confronted with the expressions of social issues that permeate the routine of work and of attention for women in the health network.

REFERENCES

1. Diniz SG, Salgado HO, Andrezzo HFA, Carvalho PGC, Carvalho PCA, Aguiar CA, et al. Violência obstétrica como questão para a saúde pública no Brasil: origens, definições, tipologia, impactos sobre a saúde materna, e propostas para sua prevenção. J Hum Growth Dev. [Internet]. 2015 [cited in 05 aug 2018]; 25(3):377-6. DOI: http://dx.doi.org/10.7322/jhgd.106080

2. Lessa S, Tonet I. Introdução à filosofia de Marx. São Paulo: Expressão Popular; 2008.

3. Marx K. O capital. São Paulo: Nova Cultural; 1996. t.1, v.I

4. Pereira P. Necessidades humanas: subsídios à crítica dos mínimos sociais. 6ed. São Paulo: Cortez; 2011. p.83

5. Souza AB, Silva LC, Alves RN, Alarcão ANJ. Fatores associados à ocorrência de violência obstétrica institucional: uma revisão integrativa da literatura. Rev Ciênc Méd. [Internet]. 2016; 25(3):115-28. Available from: https://seer.sis.puc-campinas.edu.br/seer/index.php/cienciasmedicas/article/view/3641

6. Martinelli ML. O trabalho do assistente social em contextos hospitalares: desafios cotidianos. Revista Serv Soc Soc. [Internet]. 2011 [cited in 08 aug 2018]; 107:497-508. Available from: http://www.scielo.br/pdf/sssoc/n107/07.pdf

7. Aguiar JM, Oliveira AFPL, Schraiber LB. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde. Cad Saúde Pública. [Internet]. 2013 [cited in 16 aug 2018]; 29(11):2287-96. DOI: http://dx.doi.org/10.1590/0102-311X00074912

8. Leal SYP, Lima VLA, Silva AF, Soares PDFL, Santana LR, Pereira A. Percepção de enfermeiras obstétricas acerca da violência obstétrica. Cogitare Enferm. [Internet]. 2018 [cited in 08 aug 2018]; 23(2):e52473. DOI: http://dx.doi.org/10.5380/ce.v23i1.52473

9. Rodrigues FAC, Lira SVG, Magalhães PH, Freitas ALV, Mitros VMS, Almeida PC. Violência obstétrica no processo de parturição em maternidades vinculadas à Rede Cegonha. Reprod Clim. [Internet]. 2017 [cited in 05 aug 2018]; 32(2):78-84. DOI: http://dx.doi.org/10.1016/j.recli.2016.12.001

10. Andrade PON, Silva JQP, Diniz CMM, Caminha MFC. Fatores associados à violência obstétrica na assistência ao parto vaginal em uma maternidade de alta complexidade em Recife, Pernambuco. Rev Bras Saúde Mater Infant. [Internet]. 2016 [cited in 08 aug 2018]; 16(1):29-37. DOI: http://dx.doi.org/10.1590/1806-93042016000100004

11. Pedroso CNLS, López LC. À margem da humanização? Experiências de parto de usuárias de uma maternidade pública de Porto Alegre/RS. Physis. [Internet]. 2017 [cited in 08 aug 2018]; 27(4):1163-84. DOI: http://dx.doi.org/10.1590/S0103-73312017000400016

12. Sena LM, Tesser CD. Violência obstétrica no Brasil e o ciberativismo de mulheres mães: relato de duas experiências. Interface Comum Saúde Educ.[Internet]. 2017 [cited in 12 aug 2018]; 21(60): 209-20. DOI: https:// doi.org/10.1590/1807-57622015.0896

13. Castro CM, Azevedo AFP. Narrativas sobre parto domiciliar planejado após parto hospitalar. REFACS [Internet] 2018 [cited in 05 aug 2018]; 6(1):53-62. DOI: https://doi.org/10.18554/refacs.v6i1.2794

14. Rodrigues DP, Alves VH, Penna LHG, Pereira AV, Branco MBLR, Silva LA. A peregrinação no período reprodutivo: uma vivência no campo obstétrico. Esc Anna Nery Rev Enf. [Internet]. 2015 [cited in 10 aug 2018]; 19(4):614-20. DOI: https://doi.org/10.5935/1414-8145.20150082

15. Tesser CD, Knobel R, Andrezzo HFA, Diniz SD. Violência obstétrica e prevenção quaternária: o que é e o que fazer. Rev Bras Med Fam Comunidade. [Internet]. 2015 [cited in 18 aug 2018]; 10(35):1-12. DOI: http://dx.doi.org/10.5712/rbmfc10(35)1013

16. Zanardo GLP, Calderón Uribe M, Nadal AHR, Habigzang LF. Violência obstétrica no Brasil: uma revisão narrativa. Psicol Soc. (Online). [Internet]. 2017 [cited in 02 aug 2018]; 29: e155043. DOI: http://dx.doi.org/10.1590/1807-0310/2017v29155043

17. Barbosa LC, Fabbro MRC, Machado GPR. Violência obstétrica: revisão integrativa de pesquisas quantitativas. Av Enferm. [Internet]. 2017 [cited in 17 aug 2018]; 35(2):190-207. DOI: 10.15446/av.enferm.v35n2.59637

18. Silva NM, Muniz HP. Vivências de trabalhadores em contexto de precarização: um estudo de caso em serviço de emergência de hospital universitário. Estud Pesqui Psicol. [Internet]. 2011 [cited in 20 aug 2018]; 11(3):821-40. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1808-42812011000300006&lng=pt&nrm=iso

19. Mota AES, Gomes L, Bravo MIS, Teixeira M, Marsiglia RMG, Uchôa R. Serviço social e saúde: formação e trabalho profissional. São Paulo: Cortez; 2007. 408p

20. Ribeiro MCSA, Barata RB, Almeida MF, Silva ZP. Perfil sociodemográfico e padrão de utilização de serviços de saúde para usuários e não-usuários do SUS – PNAD 2003. Ciênc Saúde Colet. [Internet]. 2006 [cited in 20 aug 2018]; 11(4):1011-22. Available from: https://www.scielosp.org/scielo.php?pid=S1413-81232006000400022&script=sci_arttext

21. Brenes AC. História da parturição no Brasil: século XIX. Cad Saúde Pública. [Internet]. 1991 [cited in 01 aug 2018]; 7(2):135-49. Available from: http://www.scielo.br/pdf/csp/v7n2/v7n2a02.pdf

22. Sanfelice CFO, Abbud FSF, Pregnolatto OS, Silva MG, Shimo AKK. Do parto institucionalizado ao parto domiciliar. Rev RENE. [Internet]. 2014 [cited in 18 aug 2018]; 15(2):362-70. DOI: 10.15253/2175-6783.2014000200022

23. Parto do Princípio. Mulheres em Rede pela Maternidade Ativa. Violência obstétrica: "Parirás com dor". Dossiê elaborado pela Rede Parto do Princípio para a CPMI da Violência Contra as Mulheres [Internet]. 2012 [cited in 15 aug 2018]. Available from: https://www.senado.gov.br/comissoes/documentos/SSCEPI/DOC%20VCM%20367.pdf

24. D'Orsi E, Bruggemann OM, Diniz CSG, Aguiar JM, Gusman CR, Torres JA, et al. Desigualdades sociais e satisfação das mulheres com o atendimento ao parto no Brasil: estudo nacional de base hospitalar. Cad. Saúde Pública. [Internet]. 2014 [cited in 17 jul 2018]; 30(Supl):S154-68. DOI: http://dx.doi.org/10.1590/0102-311X00087813

25. Norman AH, Tesser CD. Obstetrizes e enfermeiras obstetras no Sistema Único de Saúde e na Atenção Primária à Saúde: por uma incorporação sistêmica e progressiva. Rev Bras Med Fam Comunidade. [Internet]. 2015 [cited in 25 aug 2018]; 10(34):1-7. Available from: DOI: http://dx.doi.org/10.5712/rbmfc10(34)1106

26. Organização Mundial da Saúde. Declaração da OMS sobre taxas de cesáreas [Internet]. Genebra: Organização Mundial da Saúde; [2015][cited in 15 aug 2018]. Available from http://apps.who.int/iris/bitstream/10665/161442/3/WHO_RHR_15.02_por.pdf

27. Barbosa GP, Giffin K, Ângulo-Tuesta A, Gama AS, Chor D, D'Orsi E, et al. Parto cesáreo: quem o deseja? Em quais circunstâncias. Cad Saúde Pública. [Internet]. 2003 [cited in 08 aug 2018]; 19(6):1611-20. Available from: http://www.scielo.br/pdf/csp/v19n6/a06v19n6.pdf

28. Anais da 8ª Conferência Nacional de Saúde; 1986 Mar 17-21; Brasília, DF [Internet]. Brasília, DF: Centro de Documentação do Ministério da Saúde;1987 [cited in 15 aug 2018]. 430p. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/0219VIIIcns.pdf

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