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Epidemiological profile of women who suffered obstetric violence: a cross-sectional study

Perfil epidemiológico de las mujeres que sufrieron violencia obstétrica: un estudio transversal

Perfil epidemiológico de mulheres que sofreram violência obstétrica: estudo transversal

ABSTRACT
Objective: to analyze the epidemiological profile of women who are victims of obstetric violence. Methods: This is a cross-sectional study with the participants of women victims of obstetric violence in a region of the coastal lowland of the state of Rio de Janeiro, in 2018. Results: Thirty-three women were interviewed, of whom the minimum age was 18 years, the maximum was 39 years and the average was 27 years. The data reveal a higher proportion among women with complete high school, by cesarean delivery, with only one previous delivery, who were not entitled to a companion, and who were assisted by the Unified Health System. Conclusion: The present study corroborates with already published findings and evidences the need for a continuous exercise of qualification by health professionals who assist women during pregnancy, childbirth and puerperium, with subsidies from scientific evidence.
DESCRIPTORS: Women's Health; Violence Against Women; Epidemiology; Parturition; Reproductive Rights.

RESUMEN
Objetivo: analizar el perfil epidemiológico de las mujeres que han sido sometidas a violencia obstétrica. Método: Este es un estudio transversal con las participantes de mujeres víctimas de violencia obstétrica en una región de las Tierras Bajas Costeras del Estado de Río de Janeiro, en 2018. Resultados: Se entrevistó a treinta y tres mujeres, de las cuales la edad mínima era de 18 años, el máximo era de 39 años y el promedio era de 27 años. Los datos revelan una mayor proporción entre las mujeres con secundaria completa, por parto por cesárea, con sólo un parto previo, que no tenían derecho a un compañero, y que fueron asistidas por el Sistema Unificado de Salud. Conclusión: El presente estudio corrobora con hallazgos ya publicados y evidencia la necesidad de un ejercicio continuo de cualificación por parte de profesionales de la salud que ayudan a las mujeres durante el embarazo, el parto y el puerperium, con subsidios de evidencia científica.
DESCRIPTORES: Salud de la Mujer; Violencia contra la Mujer; Epidemiología; Parto; Derechos Reproductivos.

RESUMO
Objetivo: analisar o perfil epidemiológico da mulher que foi submetida a violência obstétrica. Método: Trata-se de um estudo transversal tendo como participantes mulheres vítimas de violência obstétrica em uma região da Baixada Litorânea do Estado do Rio de Janeiro, no ano de 2018. Resultados: Foram entrevistadas 33 mulheres, das quais a idade mínima foi de 18 anos, a máxima 39 anos e a média de 27 anos. Os dados revelam maior proporção entre as mulheres com ensino médio completo, via de parto cesárea, com apenas um parto anterior, que não tiveram direito a um acompanhante, e que foram assistidas pelo Sistema Único de Saúde. Conclusão: O presente estudo corrobora com achados já publicados e evidencia a necessidade de um contínuo exercício de qualificação por parte dos profissionais de saúde que assistem mulheres durante a gravidez, parto e puerpério, com subsídios das evidências cientificas.
DESCRITORES: Saúde da Mulher; Violência contra a Mulher; Epidemiologia; Parto; Direitos Reprodutivos.

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INTRODUCTION

From the twentieth century onwards, childbirth is predominantly hospital and private medicine. The act of giving birth came to be seen as pathological and potentially at risk, losing its natural essence, thus the woman becomes forgotten and taken as an object and not as a subject, in which she loses her autonomy in this relationship. This fact makes your body and your sexuality controlled by medicine. [1]

According to a survey conducted by the Perseu Abramo Foundation, one in four Brazilians is a victim of obstetric violence. [2] The Brazilian obstetric reality is characterized by a service with a large number of surgical interventions, which often becomes humiliating and even the denial of the right to the companion. Thus, it disrespects women, in addition to being against human rights. [3] The presence of a companion is a right guaranteed by Law No. 11.108/2005, [4] it is observed that this right is often not informed to the woman and, consequently, it is not guaranteed during labor, delivery and postpartum in numerous public and private hospital institutions.

Violence can have adverse consequences on the physical, mental, sexual and reproductive health of these women. [5] The expression "obstetric violence" is part of the demands of the local feminist movement and the institutional process of violence against women as a social, political and public problem. In this sense, it can be understood that the problem of obstetric violence is the result of a precariousness in the health system, which places considerable restrictions on the services offered in addition to promoting disrespectful and inhumane practices in assisting women in the process of childbirth and birth. [6]

In view of this, the present study aimed to analyze the epidemiological profile of the woman who was subjected to obstetric violence.

METHOD

This is a cross-sectional study carried out with women who went through the experience of obstetric violence in their births in a municipality in the Baixada Litorânea of the State of Rio de Janeiro in 2018. Data collection was performed through a questionnaire with closed questions, applied to study participants.

The study sample was selected from a group of pregnant women called Gestante de Vida: a space for female empowerment, a project coordinated by professors and students of the Nursing Course/Fluminense Federal University/Rio das Ostras Campus (Figure 1).

The study was approved by the Ethics Committee (CEP) of Hospital Universitário Antônio Pedro (HUAP), and is part of the research entitled "Obstetric Institutional Violence to Parturients in Public Health Services: The experience of Women", CAAE No. 1.109.636 according to Resolution No. 466/2012 of the National Health Council (CNS - Conselho Nacional de Saúde), which regulates research

Figure 1 - Flowchart of the study sample.

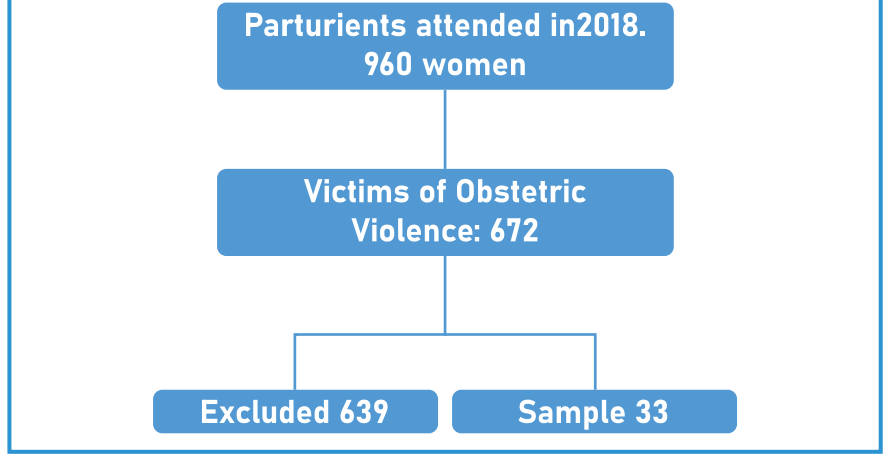
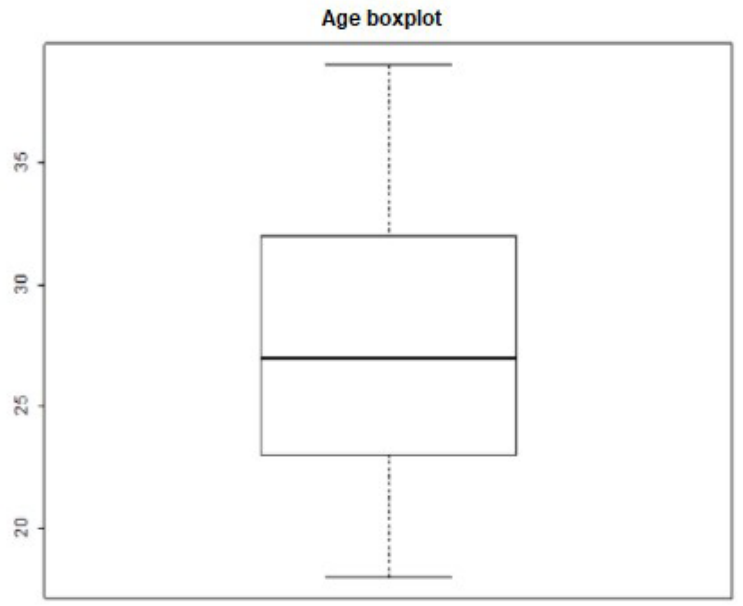


Figure 2 - Boxplot of the age distribution of women interviewed in Rio das Ostras in 2019.



Source: prepared by the authors.

Table 1 - Distribution of social and pregnancy-related variables of women in Rio das Ostras in 2019.

VARIABLES		
Age	**N=33**	**%**
Up to 19 years	2	6,1
20 to 25 years	11	33,3
26 to 30 years	9	27,3
31 to 35 years	8	24,2
36 to 39 years	3	9,1
Education	**N=33**	**%**
Incomplete elementary school	5	15,2
Complete elementary school	2	6,1
Incomplete High School	**10**	**30,3**
Complete High School	13	39,4
Incomplete higher education	1	3,0
Complete higher education	2	6,1
Way of delivery	**N=33**	**%**
Vaginal	13	39,4
Cesarean	14	42,4
Vaginal and Cesarean	5	15,2
No information	1	3,0
Gesta	**N=33**	**%**

involving human beings,[7] all participants were informed about possible discomforts and risks arising from participation, as well as about the expected benefits. Confidentiality and privacy of the participants are guaranteed.

Inclusion criteria were considered: being over 18 years old, having the desire to participate in the research, having had at least one delivery in the city of Rio das Ostras. Participants who had obstetric complications during pregnancy, labor and/or delivery, as well as women who had premature births, stillborn and/or neomort were excluded from the research. The collected data were entered into an electronic spreadsheet and processed in the R Program, which is free and available for download at http://cran.r-project.org/mirrors.html. The proportion and measures of central tendency were calculated.

RESULTS

33 women were interviewed, of whom the minimum age was 18 years old, the maximum age 39 years old and the average 27 years old (Figure 2). The age group with the lowest proportion was observed in the group aged up to 19 years (6,1%) and the largest aged 20 to 25 years (33,3%). Regarding education, the highest proportion was found among women with complete secondary education (39,4%) and the lowest among those with complete primary education (6,1%) and complete higher education (6,1%). (Table 1).

In the analysis of the mode of delivery, the difference was small between vaginal and cesarean, but with a greater proportion for cesarean (42,4%). Regarding the number of pregnancies (GESTA), the highest proportion was observed among those with one pregnancy (30,3%) and the lowest among those with five pregnancies (6,1%). Regarding the number of deliveries (PARA), there was the highest proportion among those with one birth (39,4%) and the lowest between four and five, with 3% in each stratum (Table 1).

The analysis of variables related to the

1	10	30,3
2	6	18,2

Source: prepared by the authors.

Table 2 - Distribution of variables related to obstetric violence by women in Rio das Ostras in 2019.

VARIABLE		
Legal nature of the place of delivery	**N=33**	**%**
Public	28	84,8
Private	5	15,2
Knows what obstetric violence is	**N=33**	**%**
Yes	21	63,6
No	12	36,4
Has already suffered some obstetric violence	**N=33**	**%**
Yes	13	39,4
No	14	42,4
Doesn't know	6	18,2
When she suffered	**N=33**	**%**
Pre-delivery	4	12,1
Delivery	6	18,2
Pre-delivery and Delivery	2	6,1
Puerperium	1	3,0
Does not apply	20	60,6
Was she informed of the rights during the entire labor?	**N=33**	**%**
Yes	5	15,2
No	26	78,8
Doesn't know	2	6,1
Was the presence of a companion of your choice allowed?	**N=33**	**%**
Yes	13	39,4
No	19	57,6
Doesn't know	1	3,0
Do you know the Companion Law No. 11.108?	**N=33**	**%**
Yes	12	36,4
No	21	63,6

Source: prepared by the authors.

Table 3 – Distribution of variables related to the assistance received by the interviewees in Rio das Ostras in 2019.

VARIABLES		
Classification of assistance received	**N=33**	**%**
Excellent	12	36,4
Good	8	24,2
Good and terrible	1	3,0

place of delivery and the occurrence of obstetric violence, it was found that 84,8% of births took place in public health establishments. Regarding the receipt of information during the entire labor, the majority said yes (63,6%). As for the presence of a companion during the entire labor, it was found that the majority answered no (42,4%) (Table 2).

Regarding the assistance received by professionals in general at the time of labor, most responded as excellent (36,4%) and good (24,2%). When asked if she could choose the institution she wants to have another childbirth and if she would return to the institution of the previous childbirth, 48.5% said yes, but it is worth highlighting the stratum "I would not like to have another childbirth" (12,1%) and "There would be no such possibility (6,1%). Most reported that they did not feel traumatized (78,8%) and that it did not affect their relationship with their family and baby (90,9%) (Table 3).

DISCUSSION

The epidemiological profile of women victims of obstetric violence is related to socioeconomic, physical and cultural issues. The results show that, among the women interviewed, the majority are between 20 and 25 years old and have a low level of education. Among the women interviewed, it is possible to note that the perception of health regarding the topic addressed can be compromised, in view of the issues that cover the level of education or age of the participants, it is believed that the woman does not perceive her real situation in the face of obstetric violence.

It is important to understand that the persistence of violent acts in relation to obstetric care is characterized by the woman's lack of knowledge in relation to her sexual and reproductive rights. [8] In Brazil, most hospital births are performed by obstetricians, professionals with technician and interventionist training, who are associated with the increased incidence of cesarean sections. [9] [10]

The question of the high prevalence

Regular	6	18,2
Regular and bad	1	3,0
Bad	5	15,2
Would she return to the institution of the previous birth?	**N=33**	**%**
Yes	16	48,5
No	8	24,2
She would not like to have another delivery	4	12,1
There would be no such possibility	2	6,1
maybe	3	9,1
Did you feel traumatized?	**N=33**	**%**
Yes	6	18,2
No	26	78,8
I prefer not to give an opinion	1	3,0
Did it affect your relationship with your family and baby?	**N=33**	**%**
Yes	2	6,1
No	30	90,9
Only with someone in the family	1	3,0

Source: prepared by the authors.

of cesarean sections in the city of Rio das Ostras is an alarming data that can characterize care focused on the hospital-centered model in which the doctor is the only professional responsible for labor and delivery. [11] This fact contradicts what has been recommended by the WHO since 1985, which is considered as the ideal rate for a 10 to 15% cesarean procedure among deliveries, as well as recommending the insertion of obstetric nurses in the care of parturients at usual risk.[12]

When there is no obstetric indication, cesarean section can cause preventable risks to the health of the woman and the baby, which can increase up to 120 times the probability of respiratory disorders for the newborn and can triple the risk of death for the mother. The main risks are infection and surgical complications, in institutions with an ineffective infrastructure or unable to provide safe surgery. [9]

Physical violence and the violation of the right to information and autonomy are noticeable when interventions and practices are carried out that can be considered scientifically harmful, without the consent of the parturient or when they are authorized through distorted and incomplete information, for example: lying about dilatation of the patient, fetal vitality, and reasons for improper cesarean section indication, among others. [13] Through these facts presented by the aforementioned studies, it is possible to understand that a cesarean section surgery, without the proper indication for it, can be characterized as obstetric violence. [14]

Advancing the discussion on the profile of women who may be victims of obstetric violence is of the utmost importance, so that through studies like this we have more humanized assistance at the time of delivery.

The results show that the vast majority of births performed in the city of Rio das Ostras took place in a public institution. Of the total number of women interviewed, the majority stated that they know what obstetric violence is. However, we noticed a contradiction in the course of the interviews, because, when asked if they had information about their rights during the entire labor and if they were allowed to have a companion of their choice. When asked about their knowledge about the Companion Law, it was found that more than 60% do not have knowledge about this legislation.

At the time of delivery, the woman needs attention and explanations about the procedures and interventions that will be performed, respect and empathy, and more importantly, the possibility of having an effective participation at this stage of her life. [15] Women's knowledge about obstetric violence is not effective, as the vast majority are unaware of factors that can characterize violence during labor and delivery. This can be illustrated when they claim that they did not receive enough information about their rights during hospitalization. [16] Thus, they become vulnerable.

Advancing the discussion on the profile of women who may be victims of obstetric violence is of the utmost importance, so that through studies like this we have more humanized assistance at the time of delivery. The limitation of this study occurred in the difficulty of access to the women interviewed, as well as in the interpretation of the data obtained by the data collection.

CONCLUSION

The present study corroborates findings already published and shows the need for a continuous qualification exercise on the part of health professionals who assist women during pregnancy, childbirth and the puerperium, with subsidies from scientific evidence.

We emphasize the incorporation of changes in academic training in order to incorporate scientific evidence in the curricula of medicine and nursing, as well as an urgent change in hospital rules and routines, abolishing interventionist procedures and placing women in the position of protagonists in their process of giving birth, with empowerment and participation in decision-making. ■

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