Obstetric violence in labor and birth care in a municipality in northeast Brazil

Violência obstétrica na assistência ao parto e nascimento em um município do nordeste brasileiro

Violencia obstétrica en el parto y atención del nacimiento en un municipio del noreste de brasil

RESUMO

Objetivo: analisar a ocorrência e fatores envolvidos na violência obstétrica durante a assistência ao parto e nascimento em uma maternidade pública do nordeste brasileiro. Métodos: Trata-se de um estudo descritivo-exploratório, com abordagem quantitativa, realizado em uma maternidade municipal localizada no nordeste do Brasil, estado do Ceará. A amostra contou com 142 mulheres no puerpério imediato de parto normal ou cesariana. Utilizou-se um formulário próprio para coleta de dados. Para análise realizou-se por meio de teste estatístico. Resultados: As boas práticas prevaleceram em relação à ocorrência de violência obstétrica na assistência ao parto. As variáveis "escolaridade" e "estado civil" mostraram associação estatisticamente significante com violência obstétrica ($p<0,05$). Conclusão: Diante disso, os fatores sociodemográficos contribuem para os casos de violência obstétrica. Assim, torna-se importante o desenvolvimento de ações, com intuito de perpetuar condutas eficazes no contexto da assistência obstétrica.

DESCRITORES: Violência; Assistência ao Parto; Obstetrícia; Enfermagem.

ABSTRACT

Objective: to analyze the occurrence and factors involved in obstetric violence during labor and delivery care in a public maternity hospital in northeastern Brazil. Method: This is a descriptive-exploratory study with a quantitative approach, carried out in a municipal maternity hospital located in northeastern Brazil, state of Ceará. The sample included 142 women in the immediate postpartum period after vaginal or cesarean delivery. A specific form was used for data collection. The analysis was performed using a statistical test. Results: Good practices prevailed in relation to the occurrence of obstetric violence in childbirth care. The variables "education" and "marital status" showed a statistically significant association with obstetric violence ($p<0.05$). Conclusion: In view of this, sociodemographic factors contribute to cases of obstetric violence. Thus, it is important to develop actions in order to perpetuate effective conduct in the context of obstetric care.

DESCRIPTORS: Violence; Childbirth Care; Obstetrics; Nursing.

RESUMEN

Objetivo: analizar la ocurrencia y los factores involucrados en la violencia obstétrica durante el trabajo de parto y la atención del parto en una maternidad pública del noreste de Brasil. Métodos: Se trata de un estudio descriptivo-exploratorio, con enfoque cuantitativo, realizado en una maternidad municipal ubicada en el noreste de Brasil, estado de Ceará. La muestra incluyó a 142 mujeres en el puerperio inmediato posterior a un parto natural o por cesárea. Se utilizó un formulario específico para la recogida de datos. Para el análisis realizamos pruebas estadísticas. Resultados: Prevalecieron las buenas prácticas en relación a la ocurrencia de violencia obstétrica durante la atención del parto. Las variables "educación" y "estado civil" mostraron asociación estadísticamente significativa con la violencia obstétrica ($p<0,05$). Conclusión: Ante esto, los factores sociodemográficos se restringen a los casos de violencia obstétrica. Por lo tanto, es importante desarrollar acciones con la intención de perpetuar conductas prácticas en el contexto de la atención obstétrica.

PALABRAS CLAVE: Violencia; Asistencia de Nacimiento; Obstetricia; Enfermería.

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INTRODUCTION

Violence against women is a serious public health problem. Because it is a temporary and widespread problem throughout society, the fight against violence against women aims to improve care, requiring treatment of the issue from perspectives that go beyond resources traditionally used by the health sector, with broad and in-depth discussions, including aspects related to human rights in the context of birth. [1,2].

Among the numerous types of violence against women, obstetric violence stands out, a routine problem present in the practices of care provided to women during childbirth, which involves social, economic, gender, ethnic and institutional issues. [3]. The expression "obstetric violence" (OV), according to Marques [4], is used to refer to and include numerous forms of violence during the pregnancy-puerperal cycle. These include physical, psychological and verbal abuse, as well as unnecessary and harmful procedures such as episiotomies, bed rest during pre-delivery, enema, trichotomy, routine use of oxytocin and absence of a companion. In Brazil, one in four women have suffered obstetric violence, with disrespectful and rude behavior being the most common complaints among postpartum women. [5].

Since the creation of the Prenatal and Birth Humanization Program (PHPN - Programa de Humanização no Pré-Natal e Nascimento) in 2000 and the Rede Cegonha in 2011, the focus has been on reorganizing care by linking prenatal care to childbirth and the postpartum period, with the intention of reestablishing the physiological nature of childbirth, in which women participate actively and autonomously, with the priority of promoting improved access, coverage and quality of prenatal care, childbirth and postpartum care for the mother-child binomial. [6,7].

However, what is still observed is the lack of preparation, negligence and incompetence on the part of some professionals, whether doctors, nurses, obstetric nurses or nursing technicians. In addition, human factors are compounded by institutional issues that can considerably limit the quality of care provided. These factors, when combined, culminate in the problem of obstetric violence on a global scale, especially in developing countries. [8].

> "It is well known that there are still many cases of obstetric violence, and that these are seen as normal and acceptable interventions by most women."

Considering that care for women during pregnancy and childbirth remains a challenge for care, both in terms of quality itself and the ideological principles of care, still directed towards a medicalizing, hospital-centric and technocratic model[8], the approach to the topic of obstetric violence is relevant in order to analyze the current scenario of practices considered harmful, ineffective and inadequate.

Thus, the present research aims to analyze the occurrence and factors involved in obstetric violence during childbirth and birth care in a public maternity hospital in Northeastern Brazil.

METHODS

This is a descriptive-exploratory study, with a quantitative approach, which was carried out in a maternity hospital, in the south of the State of Ceará, in the metropolitan region of Cariri, Northeast, Brazil. The hospital institution in question is the only maternity hospital in the municipality exclusively affiliated with the Unified Health System (SUS) and considered a reference in the care of pregnant women, serving an average of 277 women per month.

The study population consisted of women in the immediate postpartum period after vaginal delivery or cesarean section. The inclusion criteria were: women aged 18 years or older; able to walk and fully communicate; and who did not have clinical and/or obstetric complications that would limit their participation. Women with cognitive deficits or serious complications at the time of data collection were excluded from the study.

To select these women, a non-probabilistic, convenience and intentional sampling technique was used. Considering the general average of vaginal and cesarean deliveries that occur in the hospital per month (277) and reducing the total number of women aged 18 or over (53), an average of 224 deliveries was totaled during the month of collection. The finite population sample calculation was used (significance: 95%, error: 5%). From the calculation below, a result of 142 women to participate in the sample was obtained.

The data were then collected in the months of April and May 2017, in the maternity ward's shared accommodation, using a form prepared by the authors to identify the women's profile and using a Checklist on the practices used during childbirth care, which are considered harmful, ineffective and inadequate according to the World Health Organization[9].

The analysis was performed based on the correlation of the predictor variables: race, marital status, education and income, with the outcome variable: obstetric violence during childbirth care.

The data were compiled and analyzed using the Statistical Package for the Social Sciences (SPSS) statistical program, version 17.0. For this purpose, bivariate statistical analysis was used, with implementation of a test (Spearman Correlation) to determine which variables showed a statistical association with obstetric violence.

The study was based on Resolution 466/12 of the National Health Council (CNS/MS), with approval report no. 2,038,171.

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Table 1 – Sociodemographic data of study participants (n=142), Crato, Ceará, Brazil, 2017.

VARIABLES		N	%
Age group	8 – 24 years 25 – 34 years 35 – 45 years	78 44 20	54,9 31,0 14,1
Demographic data	Urban area Rural area	117 25	82,4 17,7
Race	White Black and Brown Yellow	16 117 9	11,3 82,4 6,4
Marital status	Single Married and Stable union Other	32 106 4	22,5 74,7 2,8
Education	Incomplete elementary education Complete elementary education Incomplete High School Complete High School Incomplete Higher education	38 9 36 50 9	26,8 6,3 25,4 35,2 6,3
Religion	Christian No religion	126 16	88,8 11,3
Occupation	Farmer Self-employed Administrative assistant Production assistant Clerk Chambermaid Pastry Chef Party Decorator Housewife Manicurist Saleswoman Receptionist Secretary Security General services No occupation	10 7 1 4 2 1 1 1 56 1 5 1 2 1 1 48	7,0 4,1 0,7 2,9 1,4 0,7 0,7 0,7 39,4 0,7 3,5 0,7 1,4 0,7 0,7 33,8
Income	< 1 minimum income 1-3 minimum incomes	73 69	51,4 48,6
TOTAL		**142**	**100%**

n: absolute frequency, %: relative frequency | Source: Survey data, 2017.

Table 2 corresponds to the absolute and relative frequency of clinical and obstetric data considering the variables: number of pregnancies, abortions, vaginal births, cesarean sections, previous illnesses and gestational illnesses.

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Table 2 – Clinical and obstetric data of study participants (N=142), Crato, Ceará, Brazil, 2017.

VARIABLES		N	%
No. of pregnancies 1 2-4 ≥5	1 2 3 4 5 6 8 9 10	58 46 11 14 6 4 1 1 1	40,8 32,4 7,8 9,9 4,2 2,8 0,7 0,7 0,7
No. of abortions	0 1 2	114 22 6	80,3 15,5 4,2
No. of vaginal deliveries 1 2-4 ≥5	0 1 2 3 4 5 7 8	70 30 20 9 9 2 1 1	49,3 21,1 14,1 6,3 6,3 1,4 0,7 0,7
No. of cesarean deliveries 1 2-4 ≥5	0 1 2 3	54 54 26 8	38,0 38,0 18,3 5,6
Previous Diseases	Urinary tract infection Yes No	16 126	11,3 88,7
Previous Diseases	Hypertension Yes No	4 138	2,8 97,2
Diseases during pregnancy	Preeclampsia Yes No Gestational diabetes Yes No Hypertension Yes No Syphilis Yes No	12 130 3 139 17 125 4 138	8,4 91,6 2,1 97,9 11,10 88,0 2,8 97,2

**Note: Women who underwent vaginal delivery and cesarean section. | Caption: n: Absolute frequency, %: Relative frequency.*

It is important to emphasize that previous illnesses such as diabetes, heart disease, mental illness; and illnesses during the last pregnancy such as HIV-AIDS, hepatitis, cytomegalovirus and rubella, were not included in Table 2, as they did not occur in any of the women in the study.

Table 3 shows the main data on obstetric violence obtained. It is noted that some variables were excluded due to their lack of significance for the study in question. It is clear that practices that are considered harmful or unnecessary were not prevalent among the women.

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Table 3 – Data on obstetric violence (N=142), Crato, Ceará, Brazil, 2017.

VARIABLES		N	%	P-VALUE
ASSISTANCE IN LABOR, DELIVERY AND POSTPARTUM				
Lithotomy position	Yes No	52 90	36,6 63,4	
Use of oxytocin	Yes No Does not know how to inform	31 109 2	21,8 76,8 1,4	
Episiotomy	Yes No Does not know how to inform	14 126 2	9,9 88,7 1,4	
Vaginal digital examination by more than one professional	Yes No	32 110	22,5 77,5	
Kristeller maneuver	Yes No Does not know how to inform	56 60 26	39,4 42,2 18,3	
Fluid and food restriction during labor	Yes No	24 118	16,9 83,1	
Amniotomy	Yes No	16 126	11,3 88,7	
Preventing or delaying contact between the baby and the woman immediately after birth	Yes No	21 121	14,8 85,2	
Cesarean section without recommendation based on scientific evidence and without the woman's consent	Yes No	67 75	47,2 52,8	
INFORMATION, COMMUNICATION AND SUPPORT				
Going to the delivery room without full uterine dilation	Yes No	9 133	6,3 93,7	
Use of forceps without explanation	Yes No Does not know how to inform	4 77 61	2,8 54,2 42,10	
Embarrassing comments to the woman	Yes No	5 137	3,5 96,5	
FLack of explanation about procedures and patient consent	Yes No Does not know how to inform	8 133 1	5,6 93,7 0,7	
Preventing the entry of the companion chosen by the woman	Yes No	45 97	31,7 68,3	
TOTAL		142	100%	

Caption: n: Absolute frequency, %: Relative frequency. | Source: Research data, 2017.

Table 4 shows that in the univariate analysis, the variables education (incomplete high school, complete high school and incomplete higher education) and marital status (married and stable union) showed a statistical association with obstetric violence, while the variables income and race did not show significance. Regarding the variable education, there was a weak negative correlation with the variable no contact with the baby ($p<0.05$). Regarding marital status, it showed significance with the variables going to the delivery room without complete dilation and use of forceps without explanation ($p<0.05$) with weak positive and moderate negative correlations, respectively.

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Table 4 – Correlation of sociodemographic variables with obstetric violence variables that demonstrated statistical significance, Crato, Ceará, Brazil, 2017.

VARIABLES		GOING TO THE DELIVERY ROOM WITHOUT FULL DILATION	FORCEPS WITHOUT CLARIFICATION	NO CONTACT WITH THE BABY
Education	r p-value	-	-	0,18 0,04
Marital status	r p-value	0,188 0,025	0,04 0,63	-

Source: Research data, 2017.

DISCUSSION

In the present study, the highest percentage of postpartum women were between 18 and 24 years old. In a study by Pascoal et al. [10] carried out in the low-risk maternity hospital in the city of Paraíba, it was found that the highest prevalence found in relation to the age group was of postpartum women between 18 and 29 years old (64.4%), an aspect that is related to a higher fertility rate.

Regarding the variables race and marital status, the results indicated a predominance of black and brown skin color and stable union. In the study by Leite et al. [11] this same prevalence was found: 68.3% were brown and 41.7% were married.

Regarding education, the data indicate that incomplete primary education predominated, which may interfere in knowing how to differentiate between what would be an abusive or natural practice regarding childbirth assistance. Thus, Silva et al. [12] showed that low levels of education are an obstacle to these women's access to knowledge, leaving them susceptible to suffering violence during childbirth.

Regarding clinical and obstetric data, most participants in this study (40.8%) reported having had only one pregnancy; 80.3% had not had an abortion; 49.3% had never tried to have children by vaginal delivery; 38.0% of the women had undergone a cesarean section; previous diseases (urinary tract infection, hypertension) were not frequent and gestational diseases (pre-eclampsia, gestational diabetes, hypertension and syphilis) were also not predominant. In the study by Costa et al. [13] showed that 8.3% of women were diagnosed with some gestational hypertensive syndrome.

> “Regarding obstetric violence, the current research observed that the implementation of good practices was superior to that of interventions considered as practices of obstetric violence in childbirth care, becoming an advance to be considered regarding good practices in obstetric care.”

Regarding the type of delivery, it was observed that between vaginal delivery and cesarean section, the most prevalent was the latter, which should not be routinely recommended in obstetric practice. In the study by Lansky et al. [5] It was evident that the highest rate found regarding the type of delivery was for normal delivery (53.8%). Although the normal delivery rate was expressed in the majority of cases, there was a significant number of cesarean sections (46.4%).

It is important to note that cesarean section surgery, when performed under indications such as: cephalopelvic disproportion, previous scarring of the body, placenta previa, cord prolapse, transverse fetal position and other situations, is safe and essential for maternal and child health, and is also effective in reducing maternal and perinatal mortality. However, performing it without a specific clinical recommendation can add unnecessary risks without there being a clear benefit to the health of the mother-child binomial. [14]

Regarding obstetric violence, the current research observed that the implementation of good practices was superior to that of interventions considered as practices of obstetric violence in childbirth care, becoming an advance to be considered

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regarding good practices in obstetric care. Thus, Figueredo et al. in their study showed that the good practices offered by health professionals in Normal Birth Centers *(CNP - Centros de Parto Normal)* in the northern region of Brazil were superior to the situations of obstetric violence found in the present study. [15].

However, these practices still persist and there is still a long way to go in terms of humanized care.

On the other hand, the non-prevalence of situations of obstetric violence may be linked to the fact that most births were by cesarean section, where some practices, such as the liberal or routine use of episiotomy, are not indicated. It is well known that there are still many cases of obstetric violence, and that these are seen as normal and acceptable interventions by most women. Ribeiro et al. highlight that 40% of the women interviewed reported having suffered obstetric violence at some point in their reproductive life. [16] However, these practices still persist and there is still a long way to go in terms of humanized care.

Regarding the abusive practices that occur most in studies, Lansky et al. [5] revealed that the practices present were, 46.4% remained in the lithotomy position, in 23.7% the Kristeller maneuver was performed, in 30.4% an episiotomy was performed and 35.6% the performance of these procedures was not reported to them. Oliveira et al [18] found that of 29.5% of women who received assistance during vaginal delivery, 68.6% did not eat during delivery, 30.2% did not drink liquids, 37.2% did not receive non-pharmacological methods for pain relief, and 33.7% received consecutive vaginal exams by different people. A similar scenario was observed in the study population, where at least one experienced some of the situations mentioned in the study. These procedures, when performed without clinical indication, cause unnecessary pain and suffering and are not recommended by the WHO as routine procedures.

Regarding the factors involved in situations of obstetric violence, this study indicated that the variables "education" and "marital status" showed a significant statistical association with obstetric violence, diverging in some aspects from other studies. Pena et al [19] in their analysis, they observed that the variables low level of education and women of mixed race or black skin color were associated with obstetric violence.

In the study by Vedam et al. [20] in the United States, it was shown that 26.9% of socioeconomically disadvantaged black women report having suffered some type of violence during care. Therefore, black women are more likely to suffer some type of violence during childbirth and postpartum as a result of social and racial issues that influence the quality of care provided to these women.

Carmo et al.[21] showed that the presence of black women with a higher level of education may be related to a lower number of interventions, as they seek to have more access to information, allowing autonomy in relation to the care provided. In this way, professionals are questioned more by patients, avoiding the performance of some unnecessary or potentially harmful procedures.

Corroborating these findings, it is noted that there are some sociodemographic characteristics of women that influence the occurrence of practices considered harmful or unnecessary. However, it is noteworthy that there is a gradual improvement in the care provided to women during labor, delivery and the puerperium, a phenomenon highlighted in the study by Alves et al. [15].

In fact, to consolidate the necessary changes in the context of obstetric care, it is necessary to consider aspects of human, institutional and management training, which will enable, in the long term, the continuous awareness of health professionals, managers and the population in general, with the aim of bringing to light the problem of obstetric violence, promoting solid and effective strategies in order to reduce the incidence of this phenomenon on a global scale.

One limitation of this research is the possibility that some postpartum women were unable to fully express all the violence they experienced, either due to the new adaptations that the postpartum phase demands, or even due to the intense demand for attention to their newborns.

CONCLUSION

In the present study, the highest percentage of postpartum women were between 18 and 24 years old. In a study by Pascoal et al. [10] carried out in the low-ris

Data analysis showed that good practices were used during childbirth care for most of the women who participated in this study, thus demonstrating considerable progress in the humanization of childbirth care, considering the local reality.

On the other hand, it is noted that interventions considered as practices of obstetric violence were still reported by patients, highlighting that two variables presented a statistically significant relationship, namely: marital status and education.

In fact, it is important to develop actions, with the aim of perpetuating effective conduct in the context of obstetric care, based on a care model that makes it possible to provide humanized practices in labor, delivery and postpartum care to the largest possible number of women.

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