

Obstetric violence in the perception of multiparous women



A violência obstétrica na percepção das multiparas
Violencia obstétrica en la percepción de multiparas

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ABSTRACT

Objective: To know the perception of multiparous women about their experiences with obstetric violence.

Methods: Qualitative descriptive study carried out from January to May 2019 in basic health units in the city of Rio Grande, Rio Grande do Sul. Twenty multiparous women from the community participated in the study. Data were collected through interviews and submitted to content analysis.

Results: Two subcategories were constructed: Obstetric Violence in primiparous women, where women suffered verbal violence to collaborate during fetal expulsion in labor; Obstetric violence in multiparous women, where there was verbal and physical violence related to the fact that the women had many children.

Final considerations: Obstetric violence in health institutions is experienced by many women. The trauma suffered will follow them through their lives. The naturalization of violent practices during labor and birth should be avoided, in order to ensure respectful and non-discriminatory care.

Keywords: Gender-based violence. Parity. Nursing.

RESUMO

Objetivo: Conhecer a percepção das multiparas acerca das suas experiências com a violência obstétrica.

Métodos: Estudo qualitativo descritivo realizado de janeiro a maio de 2019 nas unidades básicas de saúde do município de Rio Grande, Rio Grande do Sul. Participaram 20 mulheres multiparas da comunidade. Os dados foram coletados por entrevistas e submetidos à análise de conteúdo.

Resultados: Foram construídas duas subcategorias: Violência Obstétrica quando primíparas, onde as mulheres sofriam violência verbal para colaborar com o período expulsivo do parto; Violência Obstétrica quando multiparas, onde foi observada violência verbal e física, pautadas pelo grande número de filhos que possuíam.

Considerações finais: A violência obstétrica nas instituições de saúde é fato vivenciado por muitas mulheres. O trauma sofrido as acompanha ao longo da vida. É preciso evitar a naturalização de práticas violentas durante o processo de parto/nascimento garantindo um cuidado respeitoso e sem discriminação.

Palavras-chave: Violência de gênero. Paridade. Enfermagem.

RESUMEN

Objetivo: Conocer la percepción de las mujeres multiparas sobre sus experiencias con la violencia obstétrica.

Métodos: Estudio descriptivo cualitativo llevado a cabo de enero a mayo de 2019 en unidades básicas de salud en la ciudad de Rio Grande, Rio Grande do Sul. Participaron veinte mujeres multiparas de la comunidad. Los datos fueron recolectados a través de entrevistas y sometidos a análisis de contenido.

Resultados: Se construyeron dos subcategorías: violencia obstétrica cuando era primípara, donde las mujeres sufrían violencia verbal para colaborar con el período expulsivo del parto; Violencia obstétrica cuando es multipara, donde se observó violencia verbal y física, guiada por la gran cantidad de niños que tuvieron.

Consideraciones finales: La violencia obstétrica en las instituciones de salud es un hecho experimentado por muchas mujeres. El trauma sufrido los acompaña a lo largo de sus vidas. Es necesario evitar la naturalización de las prácticas violentas durante el proceso de nacimiento / parto, garantizando una atención respetuosa y no discriminatoria.

Palabras clave: Violencia de género. Paridad. Enfermería.

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INTRODUCTION

The concept of obstetric violence (OV) emerged in Latin America in 2000 from movements for the humanization of childbirth⁽¹⁾. In June 2000, the Brazilian Ministry of Health recognized the term Obstetric Violence. OV is the result of patriarchal oppression that undervalues, oppresses and objectifies the female body, limiting their power and expression. In this scenario, women are deprived of their identities, are no longer considered human beings with fundamental rights, and are viewed only as wombs, a shelter for the fetus, baby-making machines⁽²⁾.

According to a publication by the World Health Organization (WHO), many women suffer abuse, disrespect and mistreatment during childbirth in health institutions worldwide. Such treatment not only violates women's rights to respectful care, but also threatens the right to life, health, physical integrity and non-discrimination. According to the publication, eliminating disrespect, abuse and mistreatment during childbirth will only be possible through an inclusive process, with the participation of women, communities, professionals and health managers⁽³⁾.

Brazil ranks second in the world in C-section rates. Although the WHO has established an ideal rate for caesarean sections up to 15%, in Brazil this percentage is 57%⁽⁴⁾. Public policies for the humanization of delivery and birth describe health care centered on women, aiming to reduce unnecessary interventions and valuing women's autonomy in childbirth.

The relevance of the topic, which has been recently discussed in 2019, justifies the present study: in May 2020 the Ministry of Health tried to remove the term "obstetric violence" from public documents. Since the issue has become the subject of intense debate, the term was not removed. In Brazil, one in every four women suffers OV during their delivery process according to a survey of 2,365 women and 1,181 men carried out by ABRAMO and SESC in 2010⁽⁵⁾.

A broader discussion of the topic, including recent data and other realities, can help in the construction of strategies to face the issue. Thus, the guiding question proposed for this study was "How do multiparous women perceive their experiences of obstetric violence?" It aimed to provide a better understanding on the perception of multiparous women about their experiences of obstetric violence.

METHODOLOGY

This is a qualitative, descriptive-exploratory study that in addition to observing and recording the incidence of the phenomenon, seeks to explore its dimension, the way in which it manifests itself and the factors to which it is related⁽⁶⁾.

The study was carried out from January to May 2019 through interviews in the homes of participants registered in a Basic Health Unit (BHU) in the city of Rio Grande/RS. In-depth individual semi-structured interviews were conducted with 20 multiparous women to learn about their experiences of having given birth more than once. Of these, eight reported having suffered OV. Data analysis in the category Obstetric Violence generated two subcategories: Obstetric Violence in primiparous women and Obstetric Violence in multiparous women.

The inclusion criteria were having five or more living biological children and be 18 years or older. The exclusion criterion was: having memory and/or cognitive difficulties that prevented them from remembering the births. The women were recruited in the Basic Health Units in the city of Rio Grande. Data was collected through interviews previously scheduled and conducted during the visits of community health agents to the participants' homes.

The present study complied with the regulations and guidelines regarding the ethical use of human subjects in research established by Resolution 466/12 of Brazil's Ministry of Health⁽⁷⁾. The study was approved by the Research Ethics Committee of Universidade Federal do Rio Grande, according to protocol no 233/2018, on October 23, 2018. All participants signed an informed consent form. For identification purposes and to preserve the participants' anonymity, their names were replaced by a letter (M) followed by the interview order number, in which M1 is the first woman interviewed and M20 is the twentieth and last woman interviewed. The children were identified by birth order, with C1 being the first child and C11, the eleventh child of a multiparous woman. The ages of the children ranged between 3 and 33 years, indicating that the issue of obstetric violence has been going on for a long time.

The data collected was analyzed using Bardin's content analysis⁽⁸⁾. In this type of analysis, the theme represents a unit of meaning that leads to the formation of smaller units of meaning (nuclei). The stages of content analysis are pre-analysis; material exploration; treatment, inference and interpretation of results. In pre-analysis, the interviews were organized and systematized, and floating readings were made to identify the relationship between the content and the proposed objectives of the analysis. The stage of material exploration consisted in grouping units of similar meanings into more comprehensive categories, and in the stage of treatment, inference and interpretation of results, these were discussed based on the theoretical framework of the project. Two categories arose from the analysis: Obstetric violence in primiparous women and obstetric violence in multiparous women.

■ RESULTS

Twenty women participated in the study and all of them were multiparous. They had five to eleven children and were aged 25-74 years old. Their educational level ranged from non-literate to graduate students. Eight participants reported having suffered OV (40%) at different times of their reproductive lives. All of them were in a social vulnerability situation and without a companion. Two categories emerged from the analysis of data: when the women reported having perceived the violence at the birth of their first child and later, when they were multiparous.

Obstetric Violence in primiparous women

Initially, Obstetric Violence did not seem to be related to multiparity because it occurred at the time of the birth of the first child (C1), when the mothers were adolescents. This fact shows that the trauma suffered by these women was not forgotten, although it occurred 12 and 10 years ago, in the cases of M6 and M4, respectively. The statements below are things frequently heard by women in obstetric centers when they complain of pain.

When C1 was born, the nurse said: "When you had sex you did not complain, so why are you complaining now?" (M6)
[...]then she said to me: "Let's go at once! You girls get pregnant and don't want to feel pain!" (M4)

Moreover, health professionals often reproduce gender-based violence against other women. This indicates the existence of a sexual hierarchy. That is, more vulnerable women are subjected to a more rude and humiliating treatment. Thus, poor, black women, adolescents, women who did not have prenatal care or without a companion, sex workers, drug users, homeless women or incarcerated women are more prone to neglect or denial of care⁽⁹⁾.

When I went to the hospital for an abortion I was mistreated. I was a minor, and there was a big stir in the hospital. Everyone woke up, the professionals were stressed. I was told to abort pregnancy at home. (M7)

Trivialization of pain is the first violence suffered. Professionals are apparently stressed and do not want to hear women's complaints. The statements and procedures reported years ago by several women are always the same. Since the medicalization of childbirth, when women stopped having their children at home and went to hospitals, they had to submit themselves to the most comfortable birth position

for those who assist in birth and to other routine procedures reported. Unfortunately, this happens frequently, and there are insufficient policies aimed at improving this care.

Professionals make scary reports to demand active participation of women during childbirth, so that they push and assist in the parturition process. When primiparous women contract leg muscles because of their fear of pain and the unknown, professionals use pressure and other threats.

There's a 13-year-old girl there. [...] You saw what happened to her. I thought: -I'll have to spread my legs and push a lot. Then I, terrified, crying, said: - Don't hit me! I'll do everything you say, just don't hit me. She kept saying what I was supposed to do, and I did everything she asked promptly and quickly. (M15)

The Prenatal and Birth Humanization Program was established in 2000 by the Ministry of Health through Ordinance/GM no 569, of June 1, 2000. An official publication of 2017 reaffirmed that women in labor should be treated with respect, have access to evidence-based information and participate in decision-making. For this purpose, the professionals who assist women during childbirth must establish a relationship of trust with them, asking them about their wishes and expectations⁽¹⁰⁾. Including women in decisions about their bodies is to ensure their active participation, explaining how they can collaborate to facilitate delivery, rather than terrifying them.

Obstetric violence in multiparous women

Analysis of the statements to seek a relationship with multiparity showed that OV was related to a high number of children. The fact that the baby was not the first child of the mother seemed to leave the health team more comfortable to attack these women.

You know that this pain is normal! They treat us in a very different way because we have a lot of children. The delivery of C7 was very difficult. (M19)

Your son (C5) will die! Here in this city there is no Neonatal ICU! He will die before you arrive in Rio Grande. You already had many premature children. If this one dies, I think you will understand! (M14)

Well, is this the last one? asked the doctor who was on duty, and I replied: -Yes. I hope so. The nurse performed perineal shaving rudely. Then I saw the face of F6 in the water. I said to her: -Girl, she will drown in this water. The nurse replied: -No, she will not and continued what she was doing. I, though uncomfortable, pulled the baby. (M6)

It's not your first baby now, and you didn't care about it when you had sex! The nurse at the hospital gave me an injection (oxytocin) and I didn't need it. They always give us this injection on the gynecological table, but she gave it to me in the observation room and made me walk to the delivery room saying: - Come at once! The child will be born here on the floor! (M20)

As shown in the statements, the professionals discriminate against women who already have other children and are premature. Professionals also ask if it is the last child, but without providing contraceptive guidance to support the approach. Verbal violence is expressed in the statements about the number of children and physical violence involves unnecessary procedures, such as trichotomy and making pregnant women walk in the last stage of childbirth. According to the participants, these procedures are still used, although they are contraindicated.

Organized care is recommended for all women, to ensure them dignity, privacy, confidentiality, physical integrity and proper treatment. Care for pregnant women at the time of delivery should allow informed decision-making and receiving continuous support during labor. Routine perineal/pubic shaving prior to giving vaginal birth is not recommended. The use of intravenous fluids is not recommended to shorten the duration of labor⁽⁹⁾.

Regarding the obstetric violence mentioned, M17 suffered many types of abuse at the birth of her twins, C8 and C9. She was forced to walk after a vaginal delivery to the operating room to have the second twin cesarean. There, she suffered new situations of violence, as described below.

I told the medical students that I was afraid of having my baby with this doctor, because everyone in the city knows that she is violent. The first twin, C8, was born by vaginal delivery, but for C9, the doctor said she would use the forceps because the girl was sitting. I said no. She replied: -Well, I wasn't even in the mood. Get up. It will be a C-section. She picked me up and took me walking to the C-section room, with the umbilical cord of C8 hanging and the scissors (tweezers) on the end. (M17)

I felt the first cut of the cesarean section, and the anesthesiologist said: -She is feeling it, she is lifting her leg! The doctor replied: -She is not feeling anything. She's just making a scene. The anesthesiologist then lifted me up and said: -I'm going to give her another anesthesia! During the C-section, I saw the doctor pulling a pipe to wash, and water with blood was flowing. (M17)

The nurse said: -Calm down, everything will be fine with you. I cried and said I was feeling bad. Another doctor asked: -What are you doing? This is not a tubal sterilization. You're taking everything out of her. She said to me that she would leave the tubes in the glass. My blood pressure went up. At home I was all purple, with many cuts, I needed help to walk and walked crouched. (M17)

M17's account shows several forms of violence, mainly psychological. A publication of the WHO reports seven types of OV: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, the assistance provided is not compatible with the recommended professional standards, poor relationship between women and health professionals and health system conditions and restrictions⁽¹¹⁾.

Studies show poor patient care that is described in the following ways: lack of pain management in childbirth, occurrence of complications that threaten the physical integrity of both the woman and the baby, unnecessary exposure of the patient's intimacy, difficulties in communication, performing a procedure or exam without consent or in a non-respectful manner, discrimination by social status or color, and, above all, by rude treatment marked by the professionals' impatience or indifference and by moralistic and disrespectful statements⁽¹²⁾.

An integrative review of the past 10 years showed the scenario of obstetric violence in 13 countries. The authors refer to a profound relationship between the representation of gender ideology and the occurrence of OV. The culturally consolidated perception that women are reproductive, submissive, with physical and moral inferiority, allows domination, control, abuse and coercion of their bodies and sexuality, intertwined by discriminatory issues. Women are objectified, naturally labeled as reproductive bodies. Their subjectivity is eliminated and they are deprived of any right to choose⁽²⁾.

The trivialization of VO, naturalized in behaviors considered as "jokes" and "jokes" by health professionals is even expected by patients, who share their experiences with other women, as if it were something normal in everyday life. Another important aspect that contributes to the persistence of violent acts in obstetric care is the fact that women are unaware of their sexual and reproductive rights. In fact, women are not sure whether they have suffered violent acts, because they trust the health professionals and also because of the very condition of physical and emotional fragility caused by obstetric processes. This passivity allows the authoritarian imposition of derogatory moral values and norms by health professionals who think they know what is best for the patients who feel unable to take action⁽²⁾.

A study focused on OV in Brazil examined 33 articles and presented the analysis of the referred studies on institutional violence in childbirth. Psychological, physical and structural violence were found to be the most common in Brazilian maternity hospitals. These forms of violence are most often reported by women, although health professionals also perceive them and admit their occurrence. These are reports of professional coercion for birth via cesarean surgery, as well as psychological violence, characterized by false information, threats and the disqualification of women's decisions, with no differences between social class or type of service provider. Restraining the movements of the women at childbirth and the use of procedures without consent or explanations, as well as the use of techniques not supported by scientific evidence. These forms of violence were not generally perceived by professionals as physical violence, but rather practices designed to ensure safety that were approved by the professional authority, especially the doctor⁽¹³⁾.

Another important reflection reported by some authors is based on the paradox of the exercise of obstetric violence by female health professionals. They are sometimes described as executioners, being more violent than their male counterparts in the practice of obstetrics. There is a denial of the feminization phenomenon of gynecological obstetric care associated with the growing problem of OV and gender issues. The dichotomy of this process is also highlighted here, since female professionals who practice OV are also potential victims of this violence when they need obstetric care⁽²⁾.

Therefore, these health professionals exert their professional autonomy as if they had absolute freedom, without considering the patients' knowledge and their rights to make decisions about care. Patient care should be centered on safe care, which favors care focused on the well-being of women, although it is sustained by a repressive autonomy that has the power to determine the conducts to be performed. The lack of understanding of women's needs and the institutionalization of the prevalence of the individual values of health professionals regarding care may lead to OV⁽¹⁴⁾.

■ CONCLUSION

It was concluded that many women do not perceive themselves to be victims of obstetric violence because they do not know the term and are unable to identify the acts experienced as a violation of their physical, psychological and moral integrity. On the other hand, women who perceive violence seem to normalize, in their speeches, the violent acts experienced, as they are used to passively submit to health professionals who care for them in other spaces.

The women's reports show that multiparous women who are having their fifth child suffer greater violence compared to the violence experienced when they had their first child and were still teenagers. The fact that these women had many children seemed to authorize the healthcare team to practice obstetric violence, as they perceived in multiparity the social vulnerability of the patients.

In many statements, social vulnerability is a background in the cause of multiparity. The exposure of women to situations of helplessness, without family support, while they were still adolescent, and the fact that the government does not provide protection against violence are determining factors for the worsening of their condition.

One limitation of this study is the fact that the women did not perceive obstetric violence as actual violence, since there has been little discussion or debate on this topic in society. There is an urgent need to broaden this debate in the institutions and in the society, in order to improve the quality of health care to women during labor and delivery. Thus, further research is required. The present study can contribute to nursing teaching and care by promoting reflection on the vulnerability of women in the reported experiences.

■ REFERENCES

1. Oliveira LGSM, Albuquerque A. Violência obstétrica e direitos humanos dos pacientes. *Rev CEJ*. 2018;XXII(75):36-50.
2. Jardim DMB, Modena CM. Obstetric violence in the daily routine of care and its characteristics. *Rev Latino-Am Enfermagem*. 2018;26:e 3069. doi: <https://doi.org/10.1590/1518-8345.2450.3069>
3. Organização Mundial da Saúde (CH). Prevenção e eliminação de abusos, desrespeitos e maus tratos durante o parto em instituições de saúde. Genebra: OMS; 2014 [cited 2019 Oct 10]. Available from: https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_por.pdf?sequence=3
4. Fundo das Nações Unidas para a Infância BR). Quem espera, espera. Brasília, DF: UNICEF; 2017 [cited 2019 Oct 20]. Available from: https://www.unicef.org/brazil/media/3751/file/Quem_espera_espera.pdf
5. Fundação Perseu Abramo. (BR). Serviço Social do Comércio (BR) Mulheres brasileiras e gênero no espaço público e privado. São Paulo: FPAbramo, Sesc; 2010 [citado 2019 nov 10]. Disponível em: http://apublica.org/wp-content/uploads/2013/03/www.fpa_.org_.br_sites_default_files_pesquisaintegra.pdf
6. Polit DF, Cheryl TB. Fundamentos de pesquisa em enfermagem: avaliação de evidências para a prática da enfermagem. 9 ed. Porto Alegre: Artmed; 2018.
7. Ministério da Saúde (BR), Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. Diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. *Diário Oficial da União*. 2013 jun 13;150(112 Seção 1):59-62.
8. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.

9. World Health Organization (CH). WHO recommendations: Intrapartum care for a positive childbirth experience. Geneva: WHO; 2018 [cited 2019 Oct 24]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf?sequence=1>
10. Ministério da Saúde (BR). Diretrizes nacionais de assistência ao parto normal. Versão resumida. Brasília: Ministério da Saúde; 2017 [cited 2019 Oct 15]. Available from: http://bvsm.sau.gov.br/bvs/publicacoes/diretrizes_nacionais_assistencia_parto_normal.pdf
11. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. *PLoS Med* 2015;12(6):e1001847. doi: <https://doi.org/10.1371/journal.pmed.1001847>
12. Anuniação OS, Lamy ZC, Pereira MUL, Madeira HGR, Loyola CD, Gonçalves LLM, et al. Revés de um parto: relatos de mulheres que perderam o filho no período neonatal. *Cad Saúde Pública*. 2018;34(12): doi: <https://doi.org/10.1590/0102-311x00190517>
13. Marrero L, Brüggemann OM. Institutional violence during the parturition process in Brazil: integrative review. *Rev Bras Enferm*. 2018;71(3):1152-61. doi: <https://doi.org/10.1590/0034-7167-2017-0238>
14. Rodrigues DP. Os valores dos profissionais de saúde e sua influência no cuidado obstétrico: cotidiano das maternidades [tese] Niterói (RJ): Universidade Federal Fluminense; 2019 [cited 2019 Oct 20]. Available from: <https://app.uff.br/riuff/bitstream/1/9680/1/Diego%20Pereira%20Rodrigues.pdf>

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