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Puerperal women's perceptions of obstetric violence during labor

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ABSTRACT

Introduction: When perceptions from healthcare users regarding the services offered by health institutions are taken into account, they become a tool to improve the quality of healthcare actions. **Objective:** To understand the perception of puerperal women about obstetric violence during labor. **Methods:** A descriptive mixed-methods study was carried out in a maternity hospital in the city of São Paulo with 31 postpartum women from August to November 2020. Quantitative data were collected in the first step, followed by the collection and analysis of qualitative data based on the theoretical framework of social representations and content analysis to decompose the interview material. **Results:** Two categories were identified from the perspective of the obstetric violence perception, physical abuse, and abandonment during health care. From the perceptions of puerperal women concerning obstetric violence during labor, it was possible to identify that 11 women have experienced it. Of these, 7 did not initially mention violence, but when questioned, they indicated the occurrence of inappropriate or unnecessary practices that fit the obstetric violence definition, and 20 claimed not to have experienced violence. **Conclusion:** It was evidenced that women sometimes did not recognize that they experienced obstetric violence, and some of those women who did had received inadequate information. There is an urgent need to reflect on the current scenario of childbirth care, reformulation of care practices, and professional awareness of good practices and evidence-based medicine.

Keywords: violence against women; patient satisfaction; obstetric nursing.

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INTRODUCTION

There is a growing body of research on the experiences of parturient women during childbirth that describe a disturbing picture in private and public institutions[1].

Obstetric violence (OV) has become an extremely relevant topic given the need to improve labor and birth care practices. Numerous actions and incentives have been carried out to increase the rates of vaginal delivery, reduce unnecessary interventions, and disseminate evidence-based practices.

The categories of OV include physical abuse, imposition of non-consensual interventions, making women accept interventions during childbirth using partial or distorted information, conducting non-confidential or non-private care practices, humiliating or verbally abusing the parturient woman, discriminating women based on certain attributes, abandoning, neglecting, or refusing health care assistance, and detaining the patient in the hospital[2].

Research shows that the excess of interventions in childbirth in Brazil has been considered a type of obstetric violence, contributing to high maternal and neonatal morbidity and mortality[3].

The National Birth Survey in Brazil, held in 2012[4] showed that the use of practices that are not recommended by scientific evidence, such as the abusive use of oxytocin, immobilization of the patient in the bed, and imposed lithotomy position during childbirth persist and are frequent, in addition to high rates of episiotomy, excessive vaginal examinations, restriction of food and liquids, and amniotomy. Lack of privacy and the prohibition of having a companion during labor and birth are common, despite a federal law that guarantees these rights since 2005[5]. A study carried out in 2014[6] shows that the participants' skin color and level of education are directly related to lack of privacy, the prohibition regarding the presence of a companion during labor, and OV.

This study approaches obstetric violence from the perspective of puerperal women, from prenatal experience up to assistance during vaginal delivery. It is believed that perceptions from healthcare users regarding the services offered by health institutions can be used to improve the quality of healthcare actions. In this sense, a better resolution of the assistance provided by health professionals is to understand women's needs, expand healthcare facility capacity, and improve interventions aimed at the real problems identified[7].

Thus, this study aimed to understand the perception of puerperal women about obstetric violence during labor.

METHODS

A descriptive study was carried out with a mixed (or quantitative-qualitative approach). This study design combines quantitative and qualitative approaches and was chosen as an appropriate method to understand a phenomenon using descriptions, comparisons, and interpretations. The quantitative stage consisted of a cross-sectional, descriptive, and analytical study, while the qualitative stage consisted of employing an exploratory-descriptive analysis based on the theoretical framework of social representations, which seeks to recover everyday knowledge, making it possible to discover how individuals and groups build knowledge based on their experiences[8]. The guidelines for conducting qualitative studies were followed as established by the Consolidated Criteria for Reporting Qualitative Research (COREQ)[9].

The data collection was continued until saturation was reached to endorse the study's validity. Care was taken to conduct the interviews appropriately to ensure that the questions were properly understood. All interviews were recorded using a voice recorder. At all stages of the study, the researchers met to reach a consensus. The researchers clearly and understandably transferred the study results to the data reader.

The study setting was the rooming-in of a maternity hospital located in the east of São Paulo, Brazil. The rooming-in in which the study was carried out admits puerperal women from two sectors, the Humanized Delivery Center and the Obstetric Center. The sample consisted of 31 postpartum women.

The inclusion criteria were primiparous women aged 18 or older and having had a delivery in the Humanized Delivery Center or the Obstetric Center. Women with cognitive impairment that could interfere with completing the interviews were excluded. The approximation process with the eligible participants took place in the rooming-in unit. The potential participants were invited to participate in the study voluntarily after being clarified about the study, its objectives, and the proposed methodology. All participants signed an informed consent.

The collection of quantitative data was carried out in the first stage through a semi-structured interview by the researchers, composed of the following variables: 1) socio-demographic characteristics (age, skin color, nationality, marital status, religion, education, paid activity, occupation, and family income in minimum wages), and 2) information related to prenatal care (location, number of consultations, reception in the healthcare unit, identification of the primary healthcare practitioner, guidance received on the birth plan, presence of a companion, type of delivery, positions adopted for delivery, and breastfeeding). The Statistical Package for the Social Sciences (SPSS) was used for the quantitative analysis, which included descriptive statistics (mean, median, standard deviation, minimum and maximum values).

Qualitative data were collected using a digital recorder to record the answers to the following guiding question: "Did the delivery go the way you imagined it? Tell me about your delivery". The purpose of the guiding question was to understand the participants' perception of the intrapartum moment, and this technique was selected because of the possibility of obtaining a wide range of data on obstetric violence from the perspective of women.

The data collection took place between August and November 2020. The average duration of the interviews was 30 minutes, and the data were submitted to content analysis, as proposed by Bardin, in three phases: pre-analysis, exploration of the material, and treatment of the results. In the pre-analysis, the listening and transcription of data and initial ideas were carried out, establishing indicators for interpreting the information collected. Subsequently, the material was coded, classified, and categorized using the IRAMUTEQ (*Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*) software.

Each interview was fully transcribed after its completion and had a number assigned consecutively. The speeches were transcribed in full, checked, and validated through an independent reading by a specialist in the area. After transcription, a careful reading of the content was carried out and covered three steps: preparation and coding of the initial text, descending hierarchical classification performed using data processing and interpretation of the classes. The 31 interviews resulted in 31 texts organized in a single file, resulting in 31 Initial Context Units (ICU) and data saturation (when there is no further generation of new information).

To ensure anonymity, each participant was named after a goddess from Greek mythology as follows: Aphrodite_1, Artemis_2, Athena_3, Alala_4, Aster_5, Aura_6, Aurora_7, Anaka_8, Arien_9, Astrild_10, Aveta_11; Áine_12, Bast_13, Brigid_14, Belisama_15, Bellona_16, Ceres_17, Demeter_18, Diana_19, Eirene_20, Freya_21, Felicitas_22, Flora_23, Gaia_24, Hariasa_25, Hersilia_26, Hebe_27, Hella_28, Hera_29, Inanna_30, Iris_31.

After the transcription was performed, the file was saved as a text document using character encoding in the UTF-8 standard (Unicode Transformation Format 8-bit), keeping only the answers in a complete and referenced way. The text segments presented in each class were obtained from the significant words from the corpus, allowing the qualitative analysis.

After processing the data, the analysis of the four classes provided by the IRAMUTEQ software began. The ICUs grouped in each class were read extensively, and each class was understood and named.

The categories of obstetric violence developed by Bower & Hill[10] and synthesized in Brazil by Tesser et al.[11] were used to analyze the participant women's perceptions. The reports were categorized into physical abuse and abandonment during healthcare. The study complied with national and international standards of ethics in research involving human beings, including Resolution 466/2012 of the Brazilian National Health Council/Ministry of Health, and was approved by the Research Ethics Committee of the Federal University of São Paulo with CAAE number 32558020.8.3001.0063.

RESULTS

The sample of 31 women interviewed had an average age of 25 years, with a minimum of 18 and a maximum of 38 years. The socio-demographic data can be found in Table 1.

Concerning the information related to prenatal care, 29 women attended consultations at Primary Healthcare Units, and 2 were followed up in a supplementary service of the healthcare network. Twenty-eight women had more than six consultations, and 30 reported that they felt welcomed by the health team. Regarding the identification of the primary healthcare practitioner, 16 women attended consultations performed exclusively by physicians, 13 by nurses and physicians, and 2 exclusively by nurses. Amid questions about the guidelines provided during prenatal care, 24 women said they did not receive any information about the birth plan, and 7 were oriented about having a birth plan. Only 12 women were informed about the importance of having a companion during prenatal care, delivery, and postpartum, and 19 were unaware of this possibility.

Among the interviewees, 21 were not instructed on the types of delivery, and 10 were told about the importance of this information in subsequent prenatal consultations. Some women looked for information from other sources. Thirteen claimed to have accessed the internet to read about labor and birth, and 16 did not seek any information other than that offered by health professionals. Regarding the delivery positions, 10 mentioned having received guidance on this topic, and 21 did not receive information about it. Concerning breastfeeding, only 10 women were instructed on baby nutrition in the first hour of life.

As for delivery and birth, 17 women progressed to vaginal delivery, 10 to cesarean delivery, and 4 to forceps delivery. Only 20

Table 1: Characterization of study participants. Sao Paulo, SP, Brazil, 2020.

Variables	n	%
Age		
18 to 29 years	24	77
30 years or older	7	23
Nationality		
Brazilian	26	84
Bolivian	2	6
Paraguayan	3	10
Marital status		
Single	7	23
Married	5	16
In a stable union	19	61
Religion		
Catholic	10	32
Christian	10	32
Atheist	8	26
Messianic	1	3
Spiritist	1	3
Jehovah's witnesses	1	3
Education		
Complete high school	16	52
Incomplete medical education	6	19
Complete higher education	3	10
Incomplete higher education	6	9
Professional activity		
Yes	13	42
No	18	58
Monthly income		
Up to 1 minimum wage	14	45
1 to 3 minimum wages	15	48
3 or more minimum wages	2	6
Occupation		
Psychologist	1	3
Dressmaker	3	11
Veterinary assistant	1	3
Designer	1	3
Seller	1	3
Administrative assistant	6	16

women reported having participated in the choice of the type of delivery. Regarding companions, due to the COVID-19 pandemic, 90.3% reported having a companion only during labor. Of the total sample, 25 women reported that no procedure was performed without their permission, and 6 reported that the vaginal examination was performed without their permission. Twenty-nine women were aware of all procedures being performed at the intrapartum.

As for interventions during labor and delivery, 18 women received analgesia, 12 underwent episiotomy, and 16 underwent amniotomy. Twenty-nine of the participants were free to walk during labor, and oxytocin infusion was administered to 23 participants. After birth, 25 women had skin-to-skin contact with the newborn, and of these, 20 were allowed to breastfeed their babies in the first hour of life.

Concerning the participants' perception of obstetric violence during intrapartum, 13 mentioned that they had experienced violence. Of these, 9 did not initially mention the term "violence". However, when questioned, they reported the occurrence of practices that can be classified as violent, inappropriate, or unnecessary according to the definition of obstetric violence[2], and 18 claimed not to have suffered obstetric violence.

The puerperal women who experienced obstetric violence had an average age of 26 years, with a minimum of 21 and a maximum of 37 years. As for nationality, 10 were Brazilian and 1 Paraguayan. Regarding self-reported skin color, 7 were brown, 2 were black, and 2 were white.

The flowing thematic categories emerged from the analysis of the interviews, considering the participant women's perspective of OV: physical abuse and abandonment during healthcare (Table 2).

DISCUSSION

Obstetric violence can be considered symbolic and institutional gender violence that affects women's daily lives. In many circumstances, this type of violence is trivialized. Considering the socio-demographic profile of the participants, most of the women had low education, were brown or black, mostly were Brazilian, and did not have a professional activity, which is a portrait of social, gender, and racial disparities. A study shows that lack of knowledge regarding childbirth, the types of delivery, and autonomy contribute to OV that affects the most vulnerable members of society[6,12,13].

A relevant aspect is a relationship between skin color and OV. The present study's findings demonstrate that women of color suffer obstetric violence more than women of other ethnicities, and many of them fail to understand that they have experienced obstetric violence as defined in the literature[2]. The lack of understanding of the violent events experienced by women is directly related to the lack of information received during prenatal care and, at the same time, reflects the lack of clarity concerning the definition of obstetric violence, which is related to other types of aggression besides physical violence[2].

Table 2: Description of thematic categories and registration units.

Thematic category	Puerperal women's reports
Physical abuse Inappropriate procedures performed without the woman's consent, clinical justification, and interventions performed painfully and repetitively, including vaginal examinations, cesarean sections, and unnecessary episiotomies. Physical immobilization in painful positions, episiotomy, and other interventions[18].	*[...] I didn't expect the application of oxytocin and medications without my permission, right? ehhhh. I expected to be able to choose the position. I wish I had given birth squatting, and I didn't have the right to give my option. I would also like not to have had an episiotomy...I consented, but I think it was forced. They told me it was necessary to help get born [...](Athena)* *[...] my delivery was not easy. It was difficult. They used forceps. I didn't imagine it to be like that, but I wanted a vaginal delivery, so they used forceps and cut me. (Felicitas)* *[...] I see everyone going through 12h, 14h of labor, [...] they told me when to push, to help my baby get born, they even put their hands on my belly and pushed it [...] (Aphrodite)* *My labor was kind of rough. I felt a lot of pain. They performed several vaginal examinations [...]. (Hera)* *They performed a vaginal examination, then listened to the baby's heart, admitted me to the hospital [...], and I was alone, when the pain increased I screamed, they noticed that I was eight fingers dilated and they took me to the delivery bed, and they did more vaginal examinations, and the baby got born (Aveta).* *[...] my vagina was swollen from so many pelvic examinations, and then I got the c-section. I didn't want to, but I did it. (Ceres)* *I imagined a normal delivery with no complications, right? [...] they pushed my belly hard, and I felt burning and tearing down there... (Aster)* *"[...] they said they would help me by giving analgesia and a little cut down there, I heard that they needed to train [...]"(Aurora)* *"[...] it was not the way I imagined. It was not natural because of the interventions. [...] (Freya)*
Abandonment during healthcare Abandonment of women during healthcare, in situations in which the woman is perceived as a complaining person, mentally decompensated, or demanding[18].	*[...] I didn't imagine it would be so painful. I've felt abandoned because I could not have anyone with me. I asked them to stay with me for 20 minutes before the baby was born because I was scared and desperate. I was alone, and no one was left with me [...] I felt abandoned and very afraid [...]. (Diana)* *[...] So, I imagined that I would be a little more monitored, especially in the hours before the delivery. For example, I expected to be guided about walking, what to do and not to do to improve the contractions, what to do during the contractions, where to get answers to these types of questions, where to get a follow-up, which hospitals have a follow-up service and which ones do not. I missed this type of care... I imagined that I would find a professional that could guide me, but I did not. (Bast)*

The invisibility of obstetric violence against black women is still a masked prejudice in our society, besides being considered a historical problem that perpetuates until the present day[13].

Some of the aspects mentioned above are related to prenatal care, and it is noteworthy that black and brown women receive less information than white women during prenatal consultations[14]. This problem persists during labor and birth since women from vulnerable groups of the population (especially brown and black women) are subject to greater risks of health complications[12].

Research carried out in Recife, in the northeast region of Brazil, corroborates the present study and shows that women who did not have completed high school were more likely to experience OV[15].

Prenatal care is an opportunity for health education and involves actions to ensure a healthy pregnancy outcome. Obstetric violence can be evidenced in any omission during prenatal care, delivery, and postpartum[16]. National studies have identified failures of health professionals to offer guidance on pregnancy, breastfeeding, childbirth, and newborn care[17,18]. Although most women (28 participants) from our study attended more than six prenatal consultations, 24 did not receive guidance about the birth plan, 19 did not receive information about the right to have a companion during labor, and 21 did not receive information about the types of delivery, positions to be adopted during labor, and breastfeeding. Once again, the findings revealed a failure in the system and consequently obscurity concerning the definition of obstetric violence.

The analyzed data in this study demonstrates the lack of information about parturient women's rights and brings up some points that require reflection. In the analysis of the interviews, from the perspective of understanding what OV is, two categories emerged, physical abuse and abandonment during healthcare.

In the first thematic category, characterized by physical abuse and inadequate procedures performed without the woman's consent or clinical justification[17], we identified through the participants' reports the use of oxytocin, excessive and painful pelvic examinations, use of the Kristeller's maneuver, and episiotomy.

Synthetic oxytocin is used to induce labor stimulating uterine contractions. This medication was introduced in 1950 when there was a shift from home birth to the hospital environment, and its use is associated with increased pain and discomfort[19].

Physical violence is related to non-compliance with good practices in childbirth care and is associated with negligence, expressed by feelings of shame, embarrassment, and pain by the women who experienced it. In hospital practice, vaginal examinations are often painfully and repeatedly practiced, without complying with standards of humanized birth, and conducted by different professionals using the "didactic purpose" as a justification[20]. In our study, one participant noticed her vagina swelling due to the various pelvic examinations performed.

Any procedure that is performed without prior explanation and patient's consent is characterized as OV, including having a vaginal examination performed by more than one professional without the patient's authorization, allowing strangers to enter the birth room (even for academic purposes) without the woman's and her partner's consent[3]. In this study, most women stated that they did not participate in decision-making about the procedures, as another study has similarly demonstrated that OV committed from practices without the parturient's consent is still a reality in the Brazilian obstetric scenario[21].

The prevalence of episiotomy in this study was considerably high, and current recommendations show that this procedure must be indicated only in special conditions and supported by scientific evidence. An episiotomy must be performed only after obtaining the patient's consent, and the literature shows that compared to routine episiotomy, restrictive episiotomy results in a reduced risk of severe vaginal-perineal trauma[22].

Obstetric violence is a serious social and public health problem, and this includes the appropriation of the body and reproductive processes of women by health professionals, expressing itself through dehumanized care, abuse of medicalization, and pathologization of natural processes. Such acts must be fought, as they have a negative impact on women's quality of life[23].

In the second thematic category, abandonment during healthcare, characterized by feelings of being abandoned or having been neglected by healthcare professionals[7], the puerperal women in our study reported that, during their labor, their main need was for emotional support. They have emphasized the importance of receiving assistance at birth, including the right to have a companion, being cared for in an environment of calm, tranquility, and security, and having a person at their side offering support and ensuring positive outcomes.

Studies claim that continuous support during childbirth improves maternal and neonatal outcomes, including increased physical and emotional well-being. The presence of a companion establishes confidence and security during childbirth, is a source of support and strength, and has the potential to reduce pain and feelings of loneliness[24,25].

Women refer to the feeling of abandonment, justifying that health professionals did not know how to communicate properly and did not inform them or their companions about the progression of childbirth, which is exacerbated in women of low socioeconomic status, affecting the quality of healthcare services provided[19]. These impersonal and distant practices prove to be a strong barrier for women to exercise their autonomy during childbirth, reflecting loneliness in the face of abandonment[25].

Good practices in intrapartum benefit women and their babies, avoid psychological and physical problems, promote good experiences in childbirth and consequently avoid harms caused by practices that are not supported by scientific knowledge[26].

This study shows that most women who suffered obstetric violence were young, mixed-race, and Brazilian. It was observed that practices

such as administering synthetic oxytocin, excessive and painful pelvic examinations, Kristeller's maneuver, and episiotomy are still prevalent in the obstetric scenario. It was evidenced that women sometimes did not recognize that they had experienced obstetric violence, and, among those who did, some of them accepted it because they had received inadequate information not based on scientific evidence. Physical abuse and abandonment during healthcare were the main categories of violence observed in this study.

It is concluded that there is an urgent need to reflect on the current labor and birth scenario, reformulate care practices, and raise professional awareness of good practices and evidence-based medicine. Last but not least, there is an urgent need for women and healthcare professionals to recognize obstetric violence in healthcare settings so that high-quality care is offered to women and newborns, and government, ministerial, municipal, and personal investments are made.

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