

Article: Obstetric Violence: Women's Perception of Assistance

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Abstract

The birth of a child should be a time of happiness and joy, but often during labor and delivery the woman may experience violence. This study aimed to find out the occurrence of violence in the assistance to labor and delivery experienced by women. Qualitative, descriptive, exploratory and cross-sectional study, developed with 25 women who had their children in hospital services and who used Bardin's content analysis proposal to discuss the data and as a theoretical reference public policies for childbirth care. The categories identified were: Interventionist actions and Women's perception of violence in labor and delivery. The interviewees reported the use of practices considered inadequate and harmful in obstetric practice, but most of them stated that they were not victims of violence and assessed the assistance as adequate. The reported violence was physical, psychological, sexual and institutional and was practiced by health professionals. Violence was linked to infrastructure and power relations, which put women in a situation of inequality and vulnerability in the face of those who should be caregivers.

Keywords: *Violence Against Women; Humanized Birth; Maternities; Humanization Of Assistance*

Introduction

Women can suffer violence during all stages of their pregnancy, but emphasis is given to what occurs during labor and delivery, a period of greatest female vulnerability. The birth of a child should be a time of happiness and joy, care and welcome, but the difficulties and problems experienced by parturient women can make this experience painful, painful and sad [1].

In recent years, institutional violence during the pregnancy-puerperal cycle has gained prominence and repercussions. Violence in maternity hospitals has been called obstetric violence. Expression used for all forms of violence and damage that occur during obstetric care and is characterized by disrespect for women's rights. It presents several forms such as: omission, neglect, physical and psychological violence, sexual abuse, use of interventions and medicines without scientific evidence and other situations that generate suffering for women and can harm their child [1-5].

Institutional violence is present regardless of the mode of delivery adopted, which may occur during vaginal or operative delivery and can be practiced by all professionals involved in the puerperal pregnancy cycle. Its consequences are the increase in the number of cesarean sections, the discouragement and refusal of normal birth, the fear of this natural process, the predominance of pain and suffering, the creation of a depersonalized, solitary and dissatisfied environment for parturients and family members [1,4,6].

This problem is a reality not only in Brazil, but also in other countries in the world, generating international mobilization, which is highlighted by the actions of the World Health Organization, which highlights the need for change in the assistance offered to women at the time of delivery, through the training of professionals [1]. In Brazil, there are several political initiatives that seek to help reverse this situation, such as: the National Humanization Policy, the Humanization Program for Prenatal and Childbirth and the Rede Cegonha [6-7]. To investigate this phenomenon, it was proposed as an objective to know the occurrence of violence in the assistance to labor and delivery experienced by women.

Materials and Methods

Qualitative, descriptive, exploratory and cross-sectional study, which used Bardin's content analysis for data analysis and as a methodological reference for public policies for childbirth assistance [6-7-8]. Developed in a municipality located in the south of the State of Minas Gerais, in 2015, with 25 women, who had children in hospital services, in the six months prior to the interview, and who resided in areas where some primary care unit was assigned to Cheers. Sampling was intentional and the number of participants defined by data saturation. The exclusion criteria were: women who had no children in the hospital service, who were born more than six months before the date of data collection and those who opted for elective cesarean section.

The women with the profile of the research were identified by registering at some of the primary care units in the municipality, internship locations and that one of the authors had access to supervise internships and practices with students. After a survey, a home visit was made and the woman was invited to participate, and with the acceptance, data collection was scheduled. The interviews were conducted in a quiet environment, free from external influences and private for social actresses, two of which took place in the neighborhood's basic health unit and the others at home and were carried out by one of the researchers. The interviews were recorded digitally and lasted an average of 30 minutes. The Free and Informed Consent Term was presented and explained, and data collection started only after authorization and signature of the document. For the interviewee under 18 years of age, the Term of Assent was presented and signed and the authorization of a responsible person was requested.

The interview script and the socio-demographic data instrument were prepared by the authors and evaluated by three expert judges in the study area. A pilot test was carried out with four mothers who met the inclusion criteria, living in a neighboring city, but who used the service in the study municipality. Data collection started by filling out a form on the participant's socioeconomic and obstetric characterization. Afterwards, a recorded interview was conducted, with guiding questions: How was your stay in the maternity ward during the period of labor and delivery? Do you think you were a victim of violence in labor and delivery?

The study followed the precepts established by Resolution no. 466/2012 of the Ministry of Health [9] and was approved by the ethics committee with a substantiated opinion number 1,092,419 / 2015. The participants were identified by the letter M of the word woman and a sequential cardinal number.

Results

The age range of the interviewees ranged from 16 to 45 years and the average age found was 28 years. Most women had completed high school (48%), 60% were married and the profession / occupation informed by 40% was home. The predominant family income was one to two minimum wages (68%) and 64% live in their own home. As for the obstetric profile, 40% were primiparous and 48% primiparous, seven interviewees had already undergone cesarean sections, 88% had no abortions and 44% reported having a live child. The last pregnancy was considered low risk for 64%. All participants underwent prenatal care, the place of consultations was the Family Health Strategy for 40%, 20% in Basic Health Units, and the others in private or private practice, with an average of 8.36 visits. Only four attended groups of pregnant women and none reported having performed a birth plan. In this research, 21 women had a normal delivery and four cesarean sections for indication.

After transcribing the interviews and analyzing them, two categories were generated: interventionist actions and women's perception of violence in labor and delivery.

Interventionist actions

In this study, 50% of women underwent a procedure that is not recommended in assisting the parturient: 45.4% used oxytocin and underwent amniotomy, Kristeller's maneuver was reported by 22.7% and 50% reported episiotomy. Women reported pain, discomfort and suffering in the face of the procedures. In addition to describing the practice of episiotomy without the woman's consent and knowledge, disrespecting her autonomy. The following statements demonstrate the women's perception of the interventions: "Of the serum, I think they put two or three sachets from that one. Oh, the pain came, mercy! That mercy serum, believe in God the Father! Then I suffered a lot of pain! Not so much to win it. People from heaven!..."(M6). Horrible (amniotomy)! Really hurts! I didn't like it! I felt a lot of pain, it made me retch, I almost threw up, wow! A lot of pain, worse than the contraction! (M3) This part is bad! It's horrible! They practically climb on top of us to push! Wow, my belly was sore afterwards! It hurt like three days! (M22) Actually, at the time of the cut he didn't tell me, he was cutting. After I won it, he asked if I had felt the spike he gave and I said that I didn't feel anything, that I didn't know that he had cut it. But he didn't say anything, only after! (M25) Oh, what a pain! When it comes to cutting it doesn't hurt. But, when will you give the points. Oh the pain! I even screamed! And I had her on my lap and I had to hold it. I was like this: ouch, ouch, ouch !. It looks like it was the clamp that took it. But they were giving anesthesia all the time. But we really feel like giving the stitches, you feel a pinch (M15).

Respondents who did not use oxytocin rated labor as positive. They associate the non-use of medication with a quiet, natural process, with little pain, fast and physiological. Women, even without the use of oxytocin, reported that the substance increases pain, demonstrating the existence of a culture of labor pain. The parturients enter the health services hoping to suffer, a fact that often ends up leading to a predilection for cesarean section because they believe that it reduces discomfort. There was no need for the serum, nothing. I thought it was good! Because I said that the serum increases the pain and it seems that you go there in the sky and come back. Without the serum, it was better, because he was born quickly and didn't need it (M16). I didn't use the serum, I don't know if it was necessary. I know they use it to increase the pain, but they say that the woman suffers a lot. There is an acquaintance who said she suffered a lot, she almost couldn't take it! (M21) Another procedure performed during labor was the vaginal touch exam. In this study, some women reported that few touches were made, only in the face of complaints or the need to assess dilation. However, other women reported that excessive touching was performed during labor, a practice that generates discomfort and pain. In this case, I think they did it three times. It was when I arrived that they did it, after they put the serum on and when she pointed it out. (M8). The touch, there came a time when I had to ask her to stop, because I couldn't take the amount of touch she was doing anymore ... Because she didn't touch for a long time and then, as she saw that she had already dilated, I was already eight, I wanted to keep doing the ringing all the time to see how it was (M2).

The detachment of the membranes to induce labor and the procedure known as cervical reduction were reported by the women in this study, inadequate care practices, but widely used: Then she touched and took the placenta, took a while, plus the night that the pain started to come. I thought it took. I asked the nurse why it hurt? He said: "it is because it took off its placenta". When she made the touch it really hurt! (M15). She helped, touched and opened it to help my son get down more quickly (M13).

Some women said that the main discomfort of touch and other procedures was shame. Speech was associated with exposure of the body and genitals during the procedure, which was often performed in front of other women, professionals and students without concern for the woman's privacy. ... I think the amount of student that moves us, I think it is bad, in the medicine part. If it was just the doctor and the resident, that's fine, but there, all morning, the students pass by. It is a lot of people, enter room ten, twenty students and start examining us. I think that takes away some of our freedom. It is bad that so many people are touching us (M1). The technician's students were standing in front of them watching what was happening. Two or three nurses remained, the doctor and these students stayed there watching. I don't know how many students there were. So, it's embarrassing! (M10). I was a little scared, a little embarrassed, because

there were other pregnant women there with me and they saw everything (delivery in the pre-delivery bed), the whole situation. At the time, we don't think why we are in pain, we want it to be born the fastest (M2).

The speech of one of the women demonstrates the importance of empowering women, who in the face of inadequate practices, can take a stand against their achievement. M2 reported that the doctor tried twice to push her belly, perform Kristeller's maneuver, stopping after her request. The doctor came and tried twice, but then I asked her not to do it, because I wanted it to come naturally, without her strength and because when she did it, both times, it hurt a lot. So I asked her not to do more and she respected me, she didn't do it anymore. She did it twice, the third time I asked her to stop and she didn't. But I think there is no need to do it, I prefer it without (M2).

During the interview the women reflected on the assistance they received. At this point, some even questioned the need for episiotomy. We keep thinking, is it really necessary to make the cut, because then it hurts, uncomfortable when sitting. We do not know if it was not possible to leave without the cut at the time, and there is an imperfection in our bodies, whether we want it or not (M9). Then she said: I'm going to do anesthesia here, because if I need to cut it, it's ready. She said "I'm going to cut it here" and I said "so cut it". But, I don't know if it was necessary, if needed, because he was too small. But she said it was necessary. If I really needed it, I don't know! (M21). Women expect to receive information, guidance and to have their doubts resolved. In the event of non-compliance with this right, questions arise as to how the procedures are performed by the health team and their need. The doubts arose only during the interview and away from the maternity environment.

Faced with the indiscriminate use of procedures and their wide dissemination, women come to believe that interventions such as: use of oxytocin, amniotomy, Kristeller's maneuver and episiotomy are always beneficial, contributing to a fast delivery, considered ideal. The following statements highlight the participants' view: The serum she said "I'm going to put a serum on you" and I said: I know, this serum is to increase the pain, you can then, because it is good to accelerate (M20). Because my bag doesn't break easily, it takes a long, long, long time! From my first one they broke, from the second one too and the third one I thought and said: the two of mine have already broken, break this one too. I said, the doctor broke up and was born. Because it takes, it takes, it takes, if it doesn't break. And will I be suffering? So it broke and I already won at once, quickly! (M17). She only helped to push because she was afraid of the baby coming back and doing harm, being stopped halfway. When she climbed up, she made that lump like that, that ball and she pushed it down (M11). I thought it was better for them to kick it, than to tear it off, you know? I thought it was better for them to give it a go and help, it was very good (M11).

Women's perception of violence in labor and delivery

The difficulty in identifying violence in labor and delivery was observed in this study in which the majority of women stated that they were not victims of violence. Ah, because I think everything that happened there should have happened! It was to help me! I don't know, we feel pain, it is not easy to have a child, I think they did what they should have done. There was a change and they warned that now there is no cesarean section on anyone, only if it is necessary, they warned and so I didn't think there was anything of abuse (M3). No way! No way! I think they were very professional, very attentive, very careful, I really enjoyed the service ... there is the best place to have a child, to be attended to (M4). The participants report that they were not victims of violence because they were informed, respected, not mistreated and because they believed that the interventions performed were necessary for labor and delivery.

However, data analysis points to the existence of some violent acts. The statements exemplify the omission and neglect of assistance. ... I checked in at one o'clock, they only saw me in the room at 5:30 o'clock, I was going to look for the techniques to let me know if they were not going to give me medicine, if they were not going to do asepsis with PVPI, I had to go ready, they didn't tell me anything, they only arrived at 5:30 am right there, there was no more information (M5). It was only when my son was almost born that I thought it was irresponsible for the doctor to answer the phone, because she almost dropped my son, the luck was that there was that table below. If it weren't for that table below, he would have fallen ... Thank God he didn't! What if it had fallen? Then nobody came to talk about what really happened.

My sister was afraid that he fell because he made a noise! Lucky he had a little table. The doctor, a pediatrician, even scared him! (M18). M18's speech highlights the use of cell phones during childbirth, causing the NB to fall, supported by the auxiliary table, preventing them from falling to the floor. The woman questions the use of the cell phone that caused her son to fall and the lack of explanations or apology from the professional, showing an omission in face of the fact, leaving a feeling of being a routine and unimportant act for the team.

Psychological violence was observed in the following statements: I think it could be less traumatic in childbirth, we go through very bad situations (M1). So, I wish I had dilated everything without oxytocin. But, as another pregnant woman arrived there and she was without the child's movements, she no longer had it and she was not dilating, she was forty-one weeks old and they decided to take her to cesarean section. Only I couldn't go for cesarean section, because I was also going to have normal. That's where I was thinking, too. I stayed there beside her listening to all that and I could accelerate a little more to be able to help her and that's where I accepted. When I accepted, they took her to the operating room (M1). It appears in the speech that the woman (M1) felt coerced to accept the decision of the professionals, since she did not want to harm another patient and the use of oxytocin to solve the issue of time stands out. M1 characterized the experience of childbirth as traumatic.

In M8's speech, verbal violence is evident: I was not doing the right strength, I was doing strength in the throat and even the doctor cursed me, said: "if you were doing the right strength, your baby had already left, do the right strength, that your baby comes out", because I couldn't stand it I was asking for a cesarean, with eight dilated fingers (M8).

Both doctors and the nursing staff tend to adopt a rude attitude towards parturients. There was a nurse there who stuck a cloth in my mouth! Gave anxiety! There was pain and a very bad taste in the cloth and I didn't like it. I told another nurse who was there. She said: "bite the cloth that helps", but in my case it didn't help, she started to feel anxious and the woman shoved the cloth in my mouth. I told my husband: "take this cloth off, I don't want a cloth" and she insisted that I keep the cloth in my mouth. My husband went and took the cloth and held the cloth, he didn't give it to her anymore, because she was going to keep putting the cloth in my mouth all the time (M8). The touch, when I got there, I did it and I had one and it was normal. Then a super rough doctor came in and she went to touch me, I had three dilatations, she did it and I even howled and she said "no, it's not like that, it doesn't hurt like that!". But I even felt her nail in my womb, I could feel it. It hurt a lot, a lot, when I was three! (M9). The speeches of M8 and M9 characterize the occurrence of physical violence. Violence is not only characterized by the presence of the cloth, but also by the conduct taken without the woman's consent and to continue even after her request to remove the object. The other woman, M9, highlights the pain she felt during the touch exam of one of the professionals to whom she attributed a "brute" posture, which can characterize sexual violence. The interviewee also reports that she was repressed by her reaction.

Some women justified the violent acts received by the inadequate dimensioning of the professionals, especially the nursing team: It hurt a lot! We called and nursing didn't come, because she was a nurse and two technicians for the whole maternity ward. So, it was complicated, a lot of childbirth in the day and only three to be taking care of everyone. That day was really hard, but other than that, all these occurrences, until it was quiet ... I think that for a maternity hospital to have a nurse and two techniques I think it is very little. I don't understand it well, but I think there is very little to take care of all the rooms, all the patients (M1). ... the techniques they used to go there a little, but they only had two for motherhood, there was a lot of normal childbirth so their attention was almost nothing for people who underwent a cesarean section (M5).

Thus, it is important to note that no woman responded with conviction that she was a victim of violence during labor and delivery, but five were in doubt whether the acts that occurred during care could be called violence. Violence, both I and the others if I see it, is not violence at all, but they enter our privacy. I think that part, a lot of people moving, on the part of the students. I know they are studying, but you have to have a control, ask for authorization to see if the person wants it or not, they invade our intimacy a little. And the lack of information. I wanted to know what I was going through. I had this right to know, to know: when will I be discharged? It is severe? Do I

need to stay here? Okay, I'll stay to be taken care of. But, they did not inform me (M1). No, let me think! I do not know what violence this issue of lack of attention and lack of guidance would bring, I do not know if this considers some violence, because I was fragile, I did not understand anything ... (M5). No, in no time! Only at the time of the cloth even though the woman wanted to stick it in my mouth! But otherwise, there was nothing. I don't think so, no! (M8). No, I was not a victim! Because they treated me well, they treated me well. They were very attentive! As for the cut I don't really know if it was necessary. But I think that (the episiotomy) was nothing serious, wrong. I just don't know if I needed it, because he (RN) was very small (M21). No, I believe not. Aside from the fact that he gave up and didn't say anything, I didn't think so. Because he was very attentive, he respected a lot, he spoke hard, he climbs on the stretcher and if I told him to wait a little he waited, he always respected. I believe not (M25). At first, women reported that they were not victims of violence, however, given the verbalization of the assistance received, caused by the interview, they started to question and doubt about the presence or not of violence. The reflection may have been influenced by this subject being highlighted in the media, the schooling of the participants and by having attended the course for pregnant women, facts that contribute to the knowledge and questions about the presence of violence in labor and delivery.

Some women also observed the violence suffered by other women: Because a girl who was on my side I thought she was, I was even afraid! ... And I saw that one was a victim when the bag burst. I thought it was an ugly scene, which really hurt the girl. I think that's why I ordered a cesarean. I looked at my husband and said: "I'm scared!", Because it was there in front of us. I thought it was brutal! (M9) There was a girl there who was very sorry for her. Her baby was already dead and they went to do the work to remove it ... The girl was dying of pain and they wanted to touch her. She said "wait a little bit" and they didn't wait, they kept cursing her, they said: "this way there will be no way to help you, help us!" (changed voice) She said she was almost winning and they didn't care, and ended up doing it in bed. The doctor turned her back and she just screamed that she was being born and they all ran back. They asked me to stay out of the room and did it right there I cried with her with pity! Because she was suffering and would not take her son home. She suffered a lot, they hurt her! (M13).

M9's speech highlights the view of the procedure as a violent act, performed brutally and performed in the presence of other parturients, without concern for privacy and the feelings of other women. The interviewee, M13, reports having observed violence during the care of a patient who had an abortion. In view of the data, it was possible to question the fact of keeping women who suffered abortion and parturients together, contributing to the psychological suffering of both and showing yet another form of institutional violence, the trivialization and dehumanization of care.

Discussion

The World Health Organization stresses that worldwide, women suffer abuse, disrespect and mistreatment during childbirth in health institutions. The experience of childbirth in Brazil is often reported as the pain of loneliness, humiliation, disrespect and aggression, with institutional practices and health professionals that create or reinforce feelings of incapacity, inadequacy and impotence for women and children. your body [1-2,5-6].

All the interventions to which the women were submitted in this work show that the parturients are constantly exposed to unnecessary and harmful practices without the concern with the humanization of care and the respect for scientific evidence. Its use is associated with the beginning of a reproductive life surrounded by trauma and sexual damage that characterize obstetric violence in labor and delivery [1-2, 10-11]. It is important to highlight that this work did not seek to discuss the need or not of the procedures, but rather, the woman's perception.

Examples of unnecessary or iatrogenic procedures performed by the health team are: physical examination without permission, routine use of synthetic hormones, digital reduction of the neck, digital detachment of the amniotic membranes, amniotomy, Kristeller maneuver and episiotomy. The professional is encouraged to introduce himself and explain the procedure to be performed [2,4,6,12].

The pain and, consequently, the suffering caused by the use of interventions and medication is evident in the women's statements, contributing to negative perceptions about normal childbirth and the increase in cesarean section rates in Brazil. Therefore, they are practices that should be avoided because they do not comply with the principles of humanization and are not in accordance with scientific evidence [1,6-7,10,12].

It is noticeable the view of the woman's body as an object of study when examined by different people without prior consent. A fact that is common in teaching hospitals where, in many cases, the parturient is not informed of the names of the people who are going to examine her or of their qualification, the need and risks of the procedures, and then they do not receive information about the results found. [6]. The World Health Organization advises that the parturient can only be examined after her authorization [2], a right that in this study was not guaranteed.

The recommendation of health guidelines is that episiotomy is not used routinely by health professionals [2]. In this work, this practice was widely used by the services, constituting a violation of the sexual and reproductive rights and the integrity of the women's body, causing physical and psychological trauma [12]. Despite having been performed, Kristeller's maneuver should be abandoned by professionals due to serious consequences arising from this procedure [2]. Its use characterizes obstetric violence.

In the speeches of the women and in the conduct of the professionals in this study, the action of accelerating delivery was evident. The need to control time is part of obstetric practices in Brazil. To speed up childbirth, women's autonomy and protagonism are disrespected, and the dynamics of labor and delivery are imposed, with a high rate of interventions and the practice of unnecessary cesarean sections [1,13]. The statements show that women are easily manipulated by the team and tend to accept the interventions and guidelines received [4,7].

The woman in labor is expected to accept pain as something natural, necessary to be experienced for the birth of the child [7]. When women do not adopt this posture, professionals tend to use authoritarian behaviors, threats, an increased tone of voice as a way to lead the patient to collaborate, acts considered by professionals as part of the exercise of their professional authority [5,12].

The non-orientation of women to the procedures contradicts scientific evidence-based medicine and the rights of women who must be informed about the need for the procedure, its indication, its risks and benefits, possible adverse effects and other alternatives [2,7,11].

The speeches show the woman's unpreparedness for labor and delivery, since they tend to reach the maternity hospitals without knowing the periods of labor, non-pharmacological methods of pain relief, their rights and terms such as the humanization of care and violence obstetric. The woman's lack of preparation contributes to her vulnerability and exposes her to violent practices [3,11,14]. In this research, most women did not participate in groups of pregnant women and even though they attended an average of eight prenatal consultations, they did not seem to be prepared or oriented.

The dimensioning of inadequate personnel mentioned by women can be understood as institutional violence, for exposing them to other violence such as neglect, inadequate assistance, among others, that is, in care whose humanization principles are not put into practice, it is not possible create a bond and guarantee quality care. The high pace of work, combined with the lack of physical, human and material resources, generates a physical and emotional exhaustion of the professional, contributing to inadequate care [5-6,13].

Violence in maternity hospitals emerges as a common practice, often banal and commonplace, not being perceived and clearly defined by those involved. The difficulty in identifying violence in labor and delivery demonstrates the complexity of this phenomenon, which involves the relationships between professionals and women and is linked to historical, cultural facts and gender relations. There is a lack of knowledge and underestimation of the problem [4,7,15-16].

For a significant change in this scenario to occur, it is necessary to promote respectful assistance to motherhood, with the progression of policies and laws that guarantee women's rights, the dissemination of information and changes in the education and training of health professionals, including solid bases of ethics, gender and human rights content. The World Health Organization and the Brazilian government have been developing actions to train nurses so that they can assume the responsibility of providing assistance based on scientific evidence and humanized [2,6,9,17].

Conclusion

It was possible to identify the use of practices considered inappropriate and harmful for labor and delivery and elements that characterize physical, psychological, sexual and institutional violence. However, the interviewees stated that they were not victims of violence and reported that childbirth assistance was adequate, characterizing the invisibility of the problem.

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