

# CONVENTIONAL PRACTICES OF CHILDBIRTH AND OBSTETRIC VIOLENCE UNDER THE PERSPECTIVE OF PUERPERAL WOMEN

## PRÁTICAS CONVENCIONAIS DO PARTO E VIOLÊNCIA OBSTÉTRICA SOB A PERSPECTIVA DE PUÉRPERAS

## PRÁCTICAS CONVENCIONALES DE PARTO Y VIOLENCIA OBSTÉTRICA BAJO LA PERSPECTIVA DE PUÉRPERAS

Vanuza Silva Campos<sup>1</sup>

Ariane Cedraz Morais<sup>2</sup>

Zannety Conceição Silva do Nascimento Souza<sup>3</sup>

Pricila Oliveira de Araújo<sup>4</sup>

**How to cite this article:** Campos VS, Morais AC, Souza ZCSN, Araújo PO. Conventional practices of childbirth and obstetric violence under the perspective of puerperal women. *Rev baiana enferm.* 2020;34:e35453.

**Objective:** to understand the experience of puerperal women with the conventional practices of childbirth and obstetric violence. **Method:** qualitative, descriptive and exploratory study, conducted with eight women in Basic Care units of a city in Bahia. Data were collected through a semi-structured interview. The data were analyzed according to the Bardin's technique. **Results:** the study revealed a scenario of poor obstetric care, disrespectful, medicalized, centered on the decision of the professional and sometimes violent, transforming the experience of childbirth for many women into a negative, frustrating and even traumatic experience. **Conclusion:** the scenario of obstetric care in some maternity hospitals in the city of study maintains conventional practices of assisted childbirth, which, in many cases, constitute as obstetric violence, given the lack of evidence to suggest the benefits and justify their use.

**Descriptors:** Natural Childbirth. Obstetric Nursing. Violence against Women.

*Objetivo:* compreender a experiência de puérperas com as práticas convencionais do parto e violência obstétrica. *Método:* estudo qualitativo, descritivo e exploratório, realizado com oito mulheres em unidades de Atenção Básica de um município da Bahia. A coleta de dados foi feita por meio de entrevista semiestruturada. Os dados foram analisados conforme a técnica de Bardin. *Resultados:* foi percebido um cenário de assistência obstétrica deficiente, desrespeitoso, medicalizado, centrado na decisão do profissional e, por vezes, violento, transformando a vivência do parto para muitas mulheres em uma experiência negativa, frustrante e até traumática. *Conclusão:* o cenário de assistência obstétrica em algumas maternidades no município de estudo mantém práticas convencionais de assistência ao parto, que, em muitos casos, constituem-se como violência obstétrica, diante da falta de evidências que apontem os benefícios e justifiquem seu uso.

*Descritores:* Parto Normal. Enfermagem Obstétrica. Violência contra a Mulher.

<sup>1</sup> Nurse. Obstetric Nursing Intern at Universidade Federal da Bahia. Salvador, Bahia, Brazil. vanuzacampos5@gmail.com. <http://orcid.org/0000-0003-2838-7895>.

<sup>2</sup> Obstetric Nurse. MSc in Women's Health. Assistant Professor at the Universidade Estadual de Feira de Santana. Feira de Santana, Bahia, Brazil. <http://orcid.org/0000-0001-9445-4596>.

<sup>3</sup> Obstetric Nurse. MSc in Nursing. Assistant Professor at the Universidade Estadual de Feira de Santana. Feira de Santana, Bahia, Brazil. <http://orcid.org/0000-0002-4573-525X>.

<sup>4</sup> Nurse. MSc in Nursing. Assistant Professor at the Universidade Estadual de Feira de Santana. Feira de Santana, Bahia, Brazil. <http://orcid.org/0000-0002-7941-9263>.

*Objetivo: comprender la experiencia de puérperas con las prácticas convencionales de parto y violencia obstétrica. Método: estudio cualitativo, descriptivo y exploratorio realizado con ocho mujeres en unidades de Atención Básica de un municipio del estado de Bahía. La recogida de datos se realizó por medio de una entrevista semi-estructurada. Los datos fueron analizados según la técnica de Bardin. Resultados: se observó un escenario de la atención obstétrica deficiente, irrespetuoso, centrado en el medicamento y en la decisión de los profesionales y a veces violento, transformando la experiencia del parto para muchas mujeres en una experiencia negativa, frustrante e incluso traumática. Conclusión: el escenario de la atención obstétrica en algunas maternidades en el municipio de estudio mantiene las prácticas convencionales de la asistencia en el parto, lo cual, en muchos casos, se constituye como la violencia obstétrica, dada la falta de pruebas que sugieren las ventajas y justifiquen su uso.*

*Descriptores: Parto Natural. Enfermería Obstétrica. Violencia contra la Mujer.*

## Introduction

The current context of birth results from a long process of transformations, and among them, childbirth is a natural and female event, which changed with the insertion of the male presence in the exercise of medicine, in order to meet the interests that did not consider women's autonomy as a priority. Then, gradually, the delivery of intimate and private character lost space for its occurrence in hospital units<sup>(1)</sup>.

This change aimed initially to reduce the high rates of maternal and perinatal mortality that affected directly the economy of the nations. The results were initially positive, with the improvement of the indicators of maternal and perinatal morbidity and mortality; but, paradoxically, childbirth was characterized as a pathological character, permeated by interventions often unnecessary. In this way, the event was denatured and became eminently medical-centered, hospitalized and medicalized<sup>(2)</sup>.

However, since the 1980s, the Ministry of Health (MOH) has sought to change this reality through formulation of proposals and policies that fully meet the needs of women and humanize care at childbirth. Even so, the obstetric care in the country is still far from ideal, since it follows the technocratic and reductionist model, with the indiscriminate use of technologies and interventions, in addition to high rates of cesarean sections, disregarding the negative consequences involved<sup>(3-4)</sup>.

In this scenario, there stands out what is currently called obstetric violence, which has increasingly gained more visibility, being characterized as any aggression or physical, verbal

or psychological harm during the pregnancy-puerperium period. Thus, the delivery - often idealized by women, because it represents a special moment of transition in the life of many of them - can be transformed into a negative and even traumatic experience. Therefore, this reality must be reviewed, in order to ensure a dignified and humanized care at birth.

In relation to the humanized care, there is still resistance of health professionals to change their practices, and researches can subsidize making decisions that result in the reformulation of the provided care. Thus, the object of research that supported this article was the experience of puerperal women with the conventional practices of childbirth and obstetric violence.

That said, giving voice to the protagonists of delivery and knowing their perceptions about this experience is one of the most reliable tools to approach this reality and to identify possible weaknesses and potentialities of the care offered by health services.

Considering the above, the objective of this article is to analyze the experience of puerperal women with the conventional practices of childbirth and obstetric violence.

## Method

A study of a qualitative, descriptive and exploratory nature, to meet the subjectivity of the theme and enhance the woman's perception of the reality experienced by her. This is a cutout of a Nursing course completion work.

The study was conducted in two Basic Health Units (BHU) and two Family Health Units (FHU) in a city in the countryside of Bahia.

The participants were eight women in the puerperal period who met the following inclusion criteria: puerperal women between the 10<sup>th</sup> and the last day of the puerperal period, who voluntarily agreed to participate in the study, carried out the pre-natal in the selected units and had vaginal delivery in the city of study.

Data collection occurred between August and December 2018, using the semi-structured interview as technique, based on the guiding question: "Tell us about your experience with the normal delivery". It took place in the BHU or FHU with which the puerperal woman had a bond, or in the own homes of those participants who judged to be more convenient and/or safer; in the latter case, the support from Community Health Workers (CHW) was requested to locate the residence.

The data were analyzed through the content analysis technique of Bardin, respecting the three stages: pre-analysis, analysis and processing of results<sup>(5)</sup>. The pre-analysis corresponded to the period of the material organization and systematization of initial ideas, in which the interviews were conducted and recorded and then fully transcribed, allowing a prior understanding of future results. The analysis consisted of the systematization, deepening and understanding of the information obtained in the previous phase, after the printing of the interviews and exhaustive reading of the material. The last phase aimed to treat the results, in order to be meaningful and valid, by grouping them into categories for better understanding.

The ethical and legal aspects were met in all stages of the research, according to Resolution n. 466/2012 of the National Health Council<sup>(6)</sup>, and the data collection occurred after the authorization of the Research Ethics Committee (CEP) of the State University of Feira de Santana (UEFS) (CAAE: 86652618.8.0000.0053 and Opinion n. 2.747.155), and agreement of the interviewees by signing of the Informed Consent Form (ICF).

All the information was kept confidential, ensuring the anonymity of participants, by adopting the replacement of real names by name

of flowers, to respect their privacy and ethical principles.

## Results and Discussion

The participants were eight puerperal women aged between 16 and 32 years, and the predominant age range was from 17 to 25 years. Most of them self-reported as *pardas* (5), unmarried (6), with complete secondary education (4), with family income equal to or greater than one minimum wage (6) and having attended more than six prenatal consultations (5). There was no quantitative difference between primigravida and multigravida participants. The deliveries were performed in different public or private maternity hospitals in the city.

### *Disrespect for the women's choice of the delivery route*

Women, in their majority, prefer the normal delivery at the expense of the surgery, as demonstrated by the study participants, but several difficulties are often imposed for the exercise of that autonomy over their bodies. Among these, in some situations, the professionals decide on the type of delivery, indicating and performing cesareans, often without taking account the criteria and/or classifications recommended<sup>(7)</sup>.

This health care model, essentially biomedical, mainly contributed to the decrease/gradual loss of autonomy and of the role of women in the moment of delivery, thus increasing the asymmetry between health professionals and users of the services<sup>(8)</sup>. In this context, in many cases, the woman is informed about the medical decision not to participate in the discussion about the choice of delivery route<sup>(9)</sup>. This can be illustrated in the statements of the interviewees Jasmine and Orchid:

*They did not ask me, but I have always preferred normal delivery. I am afraid of that cesarean section anesthesia, I am scared to death. I think that normal delivery is good [...] I do not advise cesarean section. Because the recovery is better, right? (JASMINE).*

*[...] I was afraid, because my first daughter's delivery was normal, then I said: "I will not have cesarean section [...]" I was in doubt, for me, I wanted what was the best for me. But not the person... She forced me to have a cesarean, got it? Because she said, "I will admit you if you have a cesarean section, but not normal delivery, you can go home", like this. (ORCHID).*

The interviewees' statements denote an aspect that can be observed in the daily lives of many maternity hospitals, which is the absence of dialog about the feelings of the parturient, previous experiences with childbirth, her doubts, which include the route, the use of drugs as anesthesia, if necessary, or other procedures. The women's preference for normal delivery, in many situations, is not valued by the health team providing assistance, reinforcing the decision on the delivery route based on professional predilection and the culture of the cesarean as prevention of complications.

This route of predilection of medical choice, on a large scale, is the surgical delivery, which became popular and began to be used with greater frequency, aiming to improve the assistance and the maternal and neonatal outcomes; however, its use has been excessive and indiscriminate<sup>(10)</sup>.

*She asked me if it was cesarean section or normal, she touched and said: "well, we make a cesarean section, because it will take long" [...] How was it going to take long if she barely prepared me and the boy was born, got it? [...] when she turned me to apply the spinal, I screamed... the anesthesiologist came, when he opened my legs, he said that there was no time, then she kept talking: "you saw girls, he came too fast" [...] (ORCHID).*

This report unveils the vertical decision on the type of delivery to be performed, harming the autonomy of women and infringing their right of choice. Even if the woman had no choice set about the type of delivery, she felt excluded from the decision-making process on the outcomes of her pregnancy.

On this occasion, as demonstrated in other studies, the medical professional was an inductor for the choice of delivery, even without express scientific evidence or justification for this recommendation, which relates to the common indications of unnecessary cesareans. It also contradicts the recommendations of the World Health Organization (WHO), who suggests the existence of a valid reason to interfere in the natural process of delivery<sup>(11-12)</sup>.

Still, situations like this occur routinely, especially at private institutions, which prioritize the cesarean sections often "unnecessary". As a result of this medical interventionism, the private sector has more than twice the number of surgical deliveries if compared to the public, a disproportion that suggests that this high execution of surgical delivery involves non-clinical factors<sup>(13)</sup>.

This culture fosters an obstetric cesarean assistance with little dialog, transferring to the doctor the command and the power of decision on the parturition process<sup>(14)</sup>. In addition to restricting the autonomy, such behavior deprives the woman and her newborn of the advantages offered by the normal delivery, in addition to exposing both to risks from surgical delivery, having in view that the cesarean sections, without proper indication, are associated with a greater risk for maternal and child health<sup>(13)</sup>.

However, Brazil continues to be one of the countries with the highest incidence of cesarean sections in a global context. Therefore, faced with this reality, it is necessary to review the participation and the autonomy of pregnant women in the decision on the delivery route and the outcome of their pregnancy, involving the strengthening of female empowerment by health professionals<sup>(8,13)</sup>.

Thus, it is essential that the woman knows the parturition process and prepare herself for this, reinforcing the particularity of each delivery. Therefore, she will be able to fully experience it, materializing a unique experience, in which her desires and choices are respected without judgment by the professionals involved. In turn, those actions will also ensure greater satisfaction for women when realizing the active participation in decisions about their process of parturition, thus being able to enrich their own experience with the delivery<sup>(15)</sup>.

### *Conventional practice of childbirth and obstetric violence*

The experience with the childbirth is sometimes characterized by pain, suffering and aggression. This is because, in addition to unnecessary

and/or painful interventions, there are also common restrictions scientifically untenable and professional attitudes that constitute obstetric violence (OV), whether physical, psychological or verbal. Then, the scenario commonly reflects a non-humanized assistance that provokes, in the course of childbirth, feelings of insecurity, anxiety and fear<sup>(15-16)</sup>.

Corresponding to this, the speech of the puerperal women in the present study highlighted some conventional practices of childbirth care, as the indiscriminate use of oxytocin, the routine practice of episiotomy, amniotomy, directed pushing, exclusive adoption of horizontal positions for the birth, denial of the companion, unnecessary restrictions, feelings of abandonment, neglect, devaluation of their complaints and lack of clarification. Among these, in the speeches of the participants, the use of oxytocin predominated, which is a hormone whose purpose is to initiate or increase the rhythmic contractions at any time during pregnancy, usually intravenously. Its use, however, can produce adverse effects, including tachysystole, hypertonia, uterine hyperstimulation and/or uterine rupture, and to the fetus, acute fetal distress<sup>(17)</sup>.

*My delivery was normal, they gave me intravenous serum [...] five contractions came, three weak and two strong, then I gave birth. They put me on serum to see if I had... because my water had already broken, because it broke at home, so I went there [...] they put me on serum to see if it was going to be normal or cesarean section. (AZALEIA).*

As demonstrated by this report, this intervention was performed on a routine basis, aiming to induce labor or accelerate the contractions without proper assessment and criteria, being one of the first steps to be performed on arrival at maternity hospitals. It stands out even more in the report of one participant who gave birth while the team was preparing the venoclysis:

*When I got there, they told me to sit. Meanwhile, they were preparing the room to induce, give that drug by vein, but they could not even finish doing it. I sat on the stretcher, when I sat, they told me to push, so I pushed, the boy crowned and left. (DAISY).*

From this perspective, it is important to wait for the natural evolution of labor, until

the cervical dilation reaches six centimeters, i.e., the active phase of cervical dilation. In this way, considering safe fetal and maternal conditions, the use before this threshold is not recommended, and even after reaching it, the characteristics of uterine contractility must be carefully evaluated<sup>(18)</sup>.

In many situations, the administration of oxytocin does not meet aspects, such as an indication based on scientific evidence, time of use, dosage and monitoring of effects. The current indiscriminate use happens by medical convenience or of the parturient, even being a potentially dangerous medication and used to accelerate a physiological process that would generally be achieved without this intervention<sup>(19)</sup>.

The naturalness of the reports uncovers that the puerperal women understood those procedures as routine and normal. Women often feel that they are unable to trigger labor spontaneously, therefore, the use of oxytocin is perceived as indispensable, removing the physiological potential from labor<sup>(12)</sup>.

In addition to the use of oxytocin, there was also the execution of episiotomy or “chop”, which is a cut made with scissors or scalpel in the vaginal opening, which must be done after local anesthesia and that can compromise various structures of the perineum, such as muscles, blood vessels and tendons<sup>(20)</sup>.

This practice, according to the WHO, is often used improperly, without justification for routine use, because it does not bring benefits for the mother or the baby. On the contrary, this cut brings local discomfort and pain, besides of rigidity in the perineum, when done subsequently<sup>(18,21)</sup>.

*On the occasion, they do not give you any information, because you are there... in my case, the baby was not coming, then she applied the anesthesia and cut it, then she informed me that she had to stitch it up because it had opened. (ROSE).*

In this statement, in addition to highlighting the indiscriminate use of episiotomy, there stands out the women's lack of consent or even awareness of what would be performed. This practice, in which procedures are performed

without professionals informing or explaining the need and purpose, is common and serious, because they do not give a chance to the woman have autonomy over her own body<sup>(22)</sup>.

In another perspective, the episiotomy is so culturally intertwined, being part of the imaginary of women as a positive and facilitating action for childbirth, as highlighted in the Orchid's report, who showed unsatisfied by the doctor's refusal to perform the procedure, even under her request.

*She did not cut, in my first daughter, it was cut [...] it got lacerated, injured, and she had to stitch it up, even without cutting it, then the pain ended up being worse. I asked her to cut it. (ORCHID).*

In addition to the interventions mentioned, on a smaller scale, the interviewees mentioned repetitive vaginal touches, amniotomy and directed pushing, practices also not recommended.

*I passed by the touch room with the nurse, then I went to the doctor, then they made another touch again. (DAISY).*

*They broke the water, because it was not broken. I was afraid, I think the pain was even more intense because I also was nervous back then. (SUNFLOWER).*

*For the boy to leave fast, she told me to hold my legs and pull it back and push hard to leave. (TULIP).*

In relation to "touches" or routine vaginal examination, the WHO recommends its implementation at four-hour intervals to assess the evolution of labor. Thus, attention should be paid to restrict the frequency and the total number of vaginal examinations, especially when performed by multiple professionals<sup>(18)</sup>.

The isolated practice of early amniotomy – artificially breaking the water – to prevent prolonged labor is not recommended, as there is no clear evidence that the potential benefits of the practice outweigh the potential damage<sup>(18)</sup>.

The practice known as directed pushing, which directs the woman to push hard, is also not recommended, since there is no evidence of any benefit with this technique, which can culminate in other medical interventions. The recommendation is that women follow their own desire to push, which is associated with the feeling of control and autonomy in their child birth process<sup>(18)</sup>.

Based on this discussion, the interventions in the obstetric scenario are performed on a routine basis and that the criteria established for their application are not respected by professionals. Thus, they do not consider the scientific evidence, nor the opinion, the autonomy, the participation and the willingness of women<sup>(22)</sup>.

Furthermore, there was also the prohibition, restriction or difficulties to guarantee the presence of a companion, although regulated by Federal Law n. 11,108/2005<sup>(23)</sup>. Those who, even with difficulty, had the presence of a companion, reported as a positive and tranquilizing factor.

*I think it is a norm of the hospital, they do not allow a companion during the delivery. If you have cesarean delivery, you can have one after it, but not with normal delivery. (ROSE).*

*I had my mother-in-law. I became more confident. I was more comfortable than being on my own. Because it not completely in the delivery, it was only in the room, where the baby stays. It was before delivery, because at the delivery, they say the companion can stay in the room. (AZALEA).*

*My mother was with me. It was good, because I did not want to be alone, just wanted to be with her. (CARNATION).*

The statements above corroborate a study in which women also emphasized that the presence of a companion, during the delivery, provided tranquility and calm, associating the company with the highest levels of satisfaction with the experience of childbirth, and greater, when the woman chooses this person<sup>(24)</sup>.

Similarly, another study showed that the presence of a companion, with continuous support during labor, provides emotional support, comfort and defense measures, as well as contributes to reducing possible complications and interventions<sup>(15)</sup>.

In addition to those unnecessary interventions or restrictions, this study also identified that all deliveries occurred in the lithotomy position, which is carried out with women in dorsal decubitus. Therefore, it reveals that this practice is still rooted in maternities, closely related to the hospital-centered healthcare model, constituting an important limitation of body freedom<sup>(21)</sup>.

*The woman said that I was not supposed to go to the bathroom, the nurse, in this case, otherwise, I would have him and he would fall in the toilette, so I stayed lying down, and when the contractions came, I pushed hard and he was born. She did not want to let me, so I had to obey [laughter], because I was afraid that he would fall in the toilette. (CARNATION).*

About this aspect, in western countries, the cultural factors, allied to the lack of scientific evidence, make pregnant women remain, for the most part of labor, in a horizontal position<sup>(25)</sup>. Notably, the fear is the greatest motivation for women to adopt this position, fostered by the professional, who induce them to think that any free movement will cause the baby to fall<sup>(21)</sup>.

In addition to all the aspects already reported, the following speeches denote neglect, abandonment, loneliness, mistreatment and devaluation of pain on the part of the team, which configure an obstetric violence.

*They left me in a delivery room, when they saw I was not going to bear the pain, I was already bleeding, they took me to another delivery room to help me have him. I said I could not bear the pain anymore, then she said "ah, that is how it goes", when they saw I was bleeding a lot, so I went to another room where they helped me have him, to support me. Because I was about to run away from so much pain. (SUNFLOWER).*

*Because they kept closing my leg and such, did nothing for me to have normal. I had normal virtually alone. Because they made me angry, got it? (ORCHID).*

This negative perception of the care provided by health professionals, rude and aggressive, with indifference and neglect, indicates that the woman did not find the desired support. Therefore, unsatisfactory experiences of childbirth are also closely related to levels of inattention from the team<sup>(12)</sup>.

### *Naturalization of obstetric violence*

Despite all those reports that characterize a medicalized, interventionist, professional-centered assistance, with uncomfortable or even violent situations, finally women usually evaluate the care and assistance for childbirth as good.

*I found it cool, because many people say so much, got it? Giving birth in front of the maternity, wanting or not, I was well met, the people who were there supported me, so I have nothing complain about. (ROSE).*

*The staff was good, because the doctor was always asking if I was in pain, then I said I was and he told me "yours is going to be normal, wait a little more". It was cool, they treated me well, the doctor was there all the time, the doctors were also there all the time, they examined me. (AZALEA).*

This happens because, although the violence is an old event resulting from the process of medicalization of childbirth, many people do not recognize those actions against women as a violence, but as common and routine procedures that should be performed during childbirth. Since they are commonplace, they end up unnoticed by women who suffer and mainly by society, making this violence natural<sup>(22)</sup>.

Unlike the practice of unnecessary procedures and interventions that are often unnoticed, because they are subtle and largely unknown to the general population, verbal and psychological abuse, as well as neglect and indifference, are readily perceived and experienced by women, who attribute dissatisfaction with the care received, as illustrated by the following statement:

*I did not like some nurse there, because he [the baby] swallowed the rest of the delivery, so he did not cry during childbirth, I had to call for a nurse to look at him to see what his problem was, because he was suffocating, purple [...] wanting to cry and without being able to cry. One of them found it bad I called for her, she said it was normal, that way. I said that he was feeling pain, then she wanted me to prove what he was feeling, she was so ignorant, picked him up and left. (SUNFLOWER).*

Nevertheless, for the woman who lives the delivery moment, what matters in the outcome of delivery is to hold a healthy newborn in her arms. Then, despite facing some contexts of obstetric violence, in their perception, they are secondary aspects, necessary and inherent to the parturition. In this way, the crying of the living child often cancels all the discomforts experienced.

*Boy... It was quite an experience... I am not saying it was bad. The experience is good, because in the end, it is rewarding, got it? (DAISY).*

*[...] But when I had him! The experience is different, the emotion is huge. For me it was everything, when he was born, I already felt a pain relief; in everything, when I saw his face, it was everything for me. (SUNFLOWER)*

Added to this is the fact that even before this obstetric (non-)assistance condition, in Brazil, there is no law describing obstetric violence,

unlike countries such as Venezuela and Argentina. Nonetheless, even without specific legislation, this type of violence should be fought through the effective implementation of the humanized delivery, guaranteeing the fundamental rights of the parturient. For this reason, it is essential to re-evaluate the effectiveness and the need for those obstetric interventions based on scientific evidence, taking into account especially the risks and discomforts for women<sup>(22)</sup>.

In association with the non-completion of unnecessary and harmful interventions, it is also important to provide a calm, attentive assistance, providing the appropriate guidance and care, through respectful and welcoming attitudes, which assist and promote support and comfort, reflecting a positive evolution of childbirth, with tranquility, security and confidence in the care and, consequently, ensuring the humanization of childbirth and a satisfactory experience<sup>(12)</sup>.

For humanization of assistance, in addition to avoiding unnecessary interventions imposed by hospital routines, it is understandable to recognize the cultural aspects of women and, primarily, to respect their role and the time of each one in the parturition process<sup>(11)</sup>. This conception implies that the delivery is carried out under a holistic look, with support, tenderness, kindness, appreciation and respect for the dignity of the woman who is being assisted<sup>(13)</sup>.

In this context, studies conducted internationally highlight the performance of obstetric nurses (ON) in the implementation of humanization, professionals fundamental for a restructuring of the obstetric care model. This differential is explained due to the focus that the ON use in the care for pregnant women, encouraging those women to seek good practices. Furthermore, they are related to the reduction of obstetric interventions and greater satisfaction of women – who are heard, guided and assisted in all the biopsychosocial aspects in a humanized way<sup>(21)</sup>.

Therefore, the study brings as contributions the understanding of the experience with the normal delivery from the perspective of women, since they should be the protagonists of their

deliveries and, therefore, with greater ownership to decide in partnership with the health professionals on the procedures in their delivery.

## Conclusion

Despite some progress, the obstetric care scenario in some maternities in the city of study maintains conventional practices of childbirth assistance, which, in many cases, constitute as obstetric violence, given the lack of evidence to suggest the benefits and justify their use.

In this context, the hospital environment stood out as intensifier of this type of experience due to lack of clarification to women, followed by attitudes of indifference, neglect, loss of autonomy, restriction or prohibition of companion, mistreatment and devaluation of the pain.

Therefore, the implementation of the childbirth humanization primarily involves the awareness of professionals who assist women, associated with the dissemination of information with scientific evidence for them. Humanized actions are related to empathy from the professional when providing the care, and the exercise of rights by the parturient depends on her knowledge about the process of parturition.

Linked to this, the civil society, through health councils, organizations and women's groups, need to denounce situations of obstetric violence, supervise the services based on the women's reports, to collaborate in the reduction of one of the highest rates of cesarean sections in the world, which is the Brazilian, and an obstetric violence naturalized by health professionals and silenced by health institutions.

## Collaborations:

1 – conception, design, analysis and interpretation of data: Vanuza Silva Campos and Ariane Cedraz Morais;

2 – writing of the article and relevant critical review of the intellectual content: Vanuza Silva Campos, Ariane Cedraz Morais, Zannety



Conceição Silva do Nascimento Souza and Pricila Oliveira de Araújo;

3 – final approval of the version to be published: Vanuza Silva Campos, Ariane Cedraz Morais, Zannety Conceição Silva do Nascimento Souza and Pricila Oliveira de Araújo.

## References

1. Organização Mundial da Saúde. Assistência ao parto normal: um guia prático. Relatório de um grupo técnico [Internet]. Genebra (CH); 1996 [cited 2018 Dec 26]. Available from: [http://www.saude.mppr.mp.br/arquivos/File/kit\\_atencao\\_perinatal/manuais/assistencia\\_ao\\_parto\\_normal\\_2009.pdf](http://www.saude.mppr.mp.br/arquivos/File/kit_atencao_perinatal/manuais/assistencia_ao_parto_normal_2009.pdf)
2. Brasil. Ministério da Saúde. Secretaria de Ciência, Tecnologia e Insumos Estratégicos. Departamento de Gestão e Incorporação de Tecnologias em Saúde. Diretrizes Nacionais de Assistência ao Parto Normal: Versão Resumida [Internet]. Brasília (DF); 2017 [cited 2018 Dec 26]. Available from: <https://portaldeboaspraticas.iff.fiocruz.br/biblioteca/diretrizes-nacionais-de-assistencia-ao-parto-normal-versao-resumida/>
3. Organização Mundial da Saúde. Declaração da OMS sobre Taxas de Cesáreas [Internet]. Genebra (CH); 2015 [cited 2019 Jan 10]. Available from: [https://apps.who.int/iris/bitstream/handle/10665/161442/O\\_R\\_15.02\\_f;jsessionid=83C7FC4D8BAB0E6954557A7E37BDE8E5?sequence=3](https://apps.who.int/iris/bitstream/handle/10665/161442/O_R_15.02_f;jsessionid=83C7FC4D8BAB0E6954557A7E37BDE8E5?sequence=3)
4. Medeiros RMK, Teixeira RC, Nicolini AB, Alvares AS, Corrêa ACP, Martins DP. Cuidados humanizados: a inserção de enfermeiras obstétricas em um hospital de ensino. *Rev Bras Enferm.* 2016 dez; 69(6):1091-8. DOI: <http://dx.doi.org/10.1590/0034-7167-2016-0295>
5. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.
6. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. Aprova diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos [Internet]. Brasília (DF); 2012 [cited 2019 Jan 10]. Available from: <http://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf>
7. Nascimento RP, Arantes SL, Souza EDC, Contreras L, Sales APA. Escolha do tipo de parto: fatores relatados por puérperas. *Rev Gaúcha Enferm.* 2015;36(spe):119-26. DOI: <http://dx.doi.org/10.1590/1983-1447.2015.esp.56496>
8. Kottwitz F, Gouveia HG, Gonçalves AC. Via de parto preferida por puérperas e suas motivações. *Esc Anna Nery.* 2018;22(1):e20170013. DOI: [10.1590/2177-9465-EAN-2017-0013](https://doi.org/10.1590/2177-9465-EAN-2017-0013)
9. Silva SPC, Prates RCG, Campelo BQA. Parto normal ou cesariana? Fatores que influenciam na escolha da gestante. *Rev Enferm UFSM.* 2014 jan-mar;4(1):1-9. DOI: <http://dx.doi.org/10.5902/217976928861>
10. Sanfelice CFO, Abbud FSF, Pregnoatto OS, Silva MG, Shimo AKK. Do parto institucionalizado ao parto domiciliar. *Rev Rene.* 2014 mar-abr;15(2):362-70. DOI: [10.15253/2175-6783.2014000200022](https://doi.org/10.15253/2175-6783.2014000200022)
11. Tostes NA, Seild EMF. Expectativas de Gestantes sobre o Parto e suas Percepções acerca da Preparação para o Parto. *Temas psicol.* 2016 jun;24(2):681-93. DOI: <http://dx.doi.org/10.9788/TP2016.2-15>
12. Velho MB, Santos EKA, Collaco VS. Parto normal e cesárea: representações sociais de mulheres que os vivenciaram. *Rev Bras Enferm.* 2014 mar-abr;67(2):282-9. DOI: [10.5935/0034-7167.2014003](https://doi.org/10.5935/0034-7167.2014003)
13. Vicente AC, Lima AKBS, Lima CB. Parto cesário e parto normal: uma abordagem acerca de riscos benéficos. *Temas em Saúde [Internet].* 2017 [cited 2019 Jan 17];17(4):24-35. Available from: <http://temasensaude.com/wp-content/uploads/2018/01/17402.pdf>
14. Pereira RR, Franco SC, Baldin N. A Dor e o Protagonismo da Mulher na Parturição. *Rev Bras Anestesiol [Internet].* 2011 maio-jun [cited 2019 Jan 17];61(3):376-88. Available from: <http://www.scielo.br/pdf/rba/v61n3/v61n3a14.pdf>
15. Silva AM, Silva CFA, Barros JS, Lima KBC, Lima PC, Maia JS, et al. Os benefícios da livre movimentação no parto para alívio da dor. *Rev Recien.* 2017;7(20):70-81. DOI: <https://doi.org/10.24276/rrecien2358-3088.2017.7.20.70-81>
16. Tesser CD, Knobel R, Andrezzo HFA, Diniz SG. Violência obstétrica e prevenção quaternária: o que é e o que fazer. *Rev bras med fam comunidade.* 2015;10(35):1-12. DOI: [https://doi.org/10.5712/rbmf10\(35\)1013](https://doi.org/10.5712/rbmf10(35)1013)
17. Mattos DV, Martins CA, Matao MEL, Oliveira LB. Laceração perineal associada ao uso de ocitocina exógena. *Rev enferm UFPE.* 2017 jun;11(6):2273-8. DOI: <https://doi.org/10.5205/1981-8963-v11i6a23387p2273-2278-2017>

18. World Health Organization. WHO recommendations: intrapartum care for a positive childbirth experience [Internet]. Geneva (CH); 2018 [cited 2019 Jan 7]. Available from: <https://www.who.int/publications-detail/9789241550215>
19. Clarck SL, Simpson KR, Knox GE, Garite TJ. Ocitocina: novas perspectivas para uma droga antiga. *Rev Tempus Actas Saúde Col* [Internet]. 2010 [cited 2018 Dec 25];4(4):161-72. Available from: <http://www.tempusactas.unb.br/index.php/tempus/article/view/844/807>
20. Rede Parto do Princípio. Violência Obstétrica “Parirás com dor” [Internet]. Brasília (DF); 2012 [cited 2018 Dec 26]. Available from: <https://www.senado.gov.br/comissoes/documentos/SSCEPI/DOC%20VCM%20367.pdf>
21. Mouta RJO, Pilotto DTS, Vargens OMC, Progianti JM. Relação entre posição adotada pela mulher no parto, integridade perineal e vitalidade do recém-nascido. *Rev enferm UERJ* [Internet]. 2008 out-dez [cited 2019 Jan 17];16(4):472-6. Available from: <http://www.facenf.uerj.br/v16n4/v16n4a03.pdf>
22. Santiago DC, Souza WKSS, Nascimento RF. Violência obstétrica: uma análise das consequências. *Rev Científica FASETE* [Internet]. 2017 [cited 2018 Dec 25];22:148-64. Available from: [https://www.unirios.edu.br/revistarios/media/revistas/2017/13/violencia\\_obstetrica\\_uma\\_analise\\_das\\_consequencias.pdf](https://www.unirios.edu.br/revistarios/media/revistas/2017/13/violencia_obstetrica_uma_analise_das_consequencias.pdf)
23. Brasil. Ministério da Saúde. Lei nº 11.108, de 7 de abril de 2005. Altera a Lei nº 8.080, de 19 de setembro de 1990, para garantir às parturientes o direito à presença de acompanhante durante o trabalho de parto, parto e pós-parto imediato, no âmbito do Sistema Único de Saúde - SUS. *Diário Oficial da União* [Internet]. Brasília (DF); 2005 [cited 2019 Jan 17]. Available from: [http://www.planalto.gov.br/ccivil\\_03/\\_Ato2004-2006/2005/Lei/L11108.htm](http://www.planalto.gov.br/ccivil_03/_Ato2004-2006/2005/Lei/L11108.htm)
24. Velho MB, Santos EKA, Brüggemann OM, Camargo BV. Vivência do parto normal ou cesáreo: revisão integrativa sobre a percepção de mulheres. *Texto Contexto Enferm*. 2012 abr-jun;21(2):458-66. DOI: <http://dx.doi.org/10.1590/S0104-07072012000200026>
25. Mafetoni RR, Shimo AKK. Métodos não farmacológicos para alívio da dor no trabalho de parto: revisão integrativa. *Rev Min Enferm*. 2014 abr-jun;18(2):505-12. DOI: <http://www.dx.doi.org/10.5935/1415-2762.20140037>

Received: February 7, 2020

Approved: May 11, 2020

Published: June 15, 2020



The *Revista Baiana de Enfermagem* use the Creative Commons license – Attribution -NonComercial 4.0 International. <https://creativecommons.org/licenses/by-nc/4.0/>

This article is an Open Access distributed under the terms of the Creative Commons (CC BY-NC). This license lets others remix, adapt and create upon your work to non-commercial use, and although new works must give its due credit and can not be for comercial purposes, the users do not have to license such derivative works under the same terms.