REVISTA BRASILEIRA DE MEDICINA DE FAMÍLIA E COMUNIDADE
RBMFC

www.rbmfc.org.br
ISSN 2179-7994

Research Article

Obstetric violence: between women's perception and childbirth care practices

Violência obstétrica: entre a percepção das mulheres e as práticas de assistência ao parto

Violencia obstétrica: entre la percepción de las mujeres y las prácticas de atención al parto

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Abstract

Introduction: Childbirth care includes practices that interfere directly in the women's sense of safeness, well-being and satisfaction. Procedures that are performed without indication or the women's consent can harm the health of women and their babies and impact their childbirth experience, configuring obstetric violence. **Objective:** To identify the prevalence of recommended and non-recommended practices in childbirth care, according to the World Health Organization, and the women's perception of disrespect, mistreatment and abuse. **Methods:** Cross-sectional study including 287 postpartum women randomly selected in two facilities (private and public) in the city of Porto Alegre in 2016. The participants responded to face-to-face interviews 4 weeks after delivery. A structured questionnaire was used, including variables regarding socioeconomical status, obstetric history, birth experience (care provided and interventions) and the perception of having experienced disrespect, mistreatment, or humiliation by healthcare professionals. **Results:** Among the interventions, the use of synthetic oxytocin was the most prevalent (56%), followed by amniotomy (48.5%) and episiotomy (37.1%). Uterine fundal pressure maneuver was used in 11.3% of the deliveries; within the private facility, the prevalence was 25.7% compared to 8.2% in the public. Amniotomy was performed in 48.5% of the deliveries; 55.4% in the public facility as opposed to 14.7% in the private. The cesarean section rate in the total sample was 48.1%; however, the rate in the private facility was 82.8%. The proportion of women who felt they were a victim of disrespect, mistreatment or abuse was 12.5%: 14.9% within the public hospital and 7.5% within the private hospital. As for good practices, the incentive to have a companion, the offer of liquids and food, the incentive to move around during labor, the perception of having been welcomed in the maternity ward and skin-to-skin contact were more frequent in the public facility. The feeling of being comfortable asking questions and participating in decisions was more frequent in the private maternity hospital. **Conclusions:** The application of non-recommended routine practices in childbirth care is frequent in both maternity hospitals. The public maternity hospital showed a higher prevalence of good practices compared to the private one. The prevalence of non-recommended practices is higher than the prevalence of experiencing disrespect, humiliation, or mistreatment during childbirth, as perceived by the postpartum women, suggesting a lack of recognition by women of situations of violence. In this scenario, prenatal care provides a space for exchanging information about good practices and raising awareness about practices considered obstetric violence.

Keywords: Obstetric violence; Comprehensive health care; Parturition.

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E-mail: janinicpaiz@gmail.com
Funding:
No external funding.
Ethical approval:
HMV: 46775115.0.3002.5330 – HCPA/UFRGS: 49938015.3.0000.5327.
Informed consent form:
Signed by the participants.
Provenance:
Not commissioned.
Peer review:
External.
Received: 07/13/2023.
Approved: 07/01/2024.

How to cite: Paiz JC, Souto AS, Martins ACM, Ahne SMS, Baréa M, Giugliani C. Obstetric violence: between women's perception and childbirth care practices. Rev Bras Med Fam Comunidade. 2024;19(46):3852. https://doi.org/10.5712/rbmfc19(46)3852

Resumo

Introdução: A assistência ao parto é composta de práticas que interferem diretamente no sentimento de segurança, bem-estar e satisfação das mulheres. Procedimentos aplicados sem indicação ou sem consentimento podem provocar danos e interferir na experiência de parto, configurando-se como violência obstétrica. **Objetivo:** Identificar a prevalência de práticas recomendadas e não recomendadas na assistência ao parto, segundo a Organização Mundial da Saúde, bem como a percepção das mulheres em terem vivenciado desrespeito, maus-tratos ou humilhação no parto. **Métodos:** Estudo transversal, com 287 mulheres selecionadas aleatoriamente em duas maternidades de Porto Alegre, pública e privada, em 2016. As puérperas responderam a um questionário estruturado, face a face, quatro semanas após o parto, sobre aspectos socioeconômicos, histórico de saúde, experiência de parto (práticas e intervenções) e percepção de ter sofrido desrespeito, maus-tratos ou humilhação pelos profissionais. **Resultados:** Das intervenções não recomendadas de rotina, o uso de ocitocina foi a mais prevalente (56%), seguido da amniotomia (48,5%) e da episiotomia (37,1%). A manobra de pressão fúndica uterina (Kristeller) foi realizada em 11,3% dos partos; quando estratificado por maternidade, a prevalência foi de 25,7% na privada e 8,2% na pública. A amniotomia ocorreu em 48,5% dos partos, 55,4% daqueles realizados na maternidade pública e 14,7%, na maternidade privada. A taxa geral de cesariana foi de 48,1%, 31,4% na maternidade pública e 82,8% na maternidade privada. A percepção de ter sido desrespeitada, maltratada ou humilhada ocorreu para 12,5% das mulheres entrevistadas, 14,9% na maternidade pública e 7,5% na maternidade privada. Quanto às boas práticas de assistência, o incentivo a ter acompanhante, a oferta de líquidos e alimentos, o incentivo à movimentação durante o trabalho de parto, a percepção de ter sido acolhida na maternidade e o contato pele a pele foram mais frequentes na maternidade pública. Já o sentimento de estar à vontade para fazer perguntas e participar das decisões foi mais frequente na maternidade privada. **Conclusões:** É frequente a aplicação de práticas não recomendadas de rotina na assistência ao parto em ambas as maternidades. A maternidade pública apresentou maior prevalência de boas práticas em comparação com a privada. A prevalência de práticas não recomendadas é superior à prevalência de ter sofrido desrespeito, humilhação ou maus-tratos no parto, pela percepção das puérperas, o que sugere o não reconhecimento pelas mulheres de situações de violência. Nesse cenário, a atenção pré-natal é um espaço de troca de informações sobre boas práticas e reconhecimento de práticas consideradas como violência obstétrica.

Palavras-chave: Violência obstétrica; Assistência integral à saúde; Parto.

Resumen

Introducción: La asistencia al parto está compuesta por prácticas que afectan directamente el sentimiento de seguridad, bienestar y satisfacción de las mujeres. Los procedimientos aplicados sin indicación o sin consentimiento pueden provocar daños e interferir en la experiencia de parto, configurándose como violencia obstétrica. **Objetivo:** Identificar la prevalencia de prácticas recomendadas y no recomendadas en la asistencia al parto, según la Organización Mundial de la Salud, así como la percepción de las mujeres respecto a haber experimentado falta de respeto, maltrato o humillación en el parto. **Métodos:** Estudio transversal con 287 mujeres seleccionadas aleatoriamente en dos maternidades de Porto Alegre, una pública y otra privada, en 2016. Las puérperas respondieron a un cuestionario estructurado, cara a cara, cuatro semanas después del parto, sobre aspectos socioeconómicos, antecedentes de salud, experiencia de parto (prácticas e intervenciones) y percepción de haber sufrido falta de respeto, maltrato o humillación por parte de los profesionales. **Resultados:** De las intervenciones no recomendadas de rutina, el uso de oxitocina fue el más prevalente (56%), seguido de la amniotomía (48,5%) y la episiotomía (37,1%). La maniobra de presión fundal uterina (Kristeller) se realizó en el 11,3% de los partos; al estratificar por maternidad, la prevalencia fue del 25,7% en la privada y del 8,2% en la pública. La amniotomía ocurrió en el 48,5% de los partos, siendo el 55,4% en la maternidad pública y el 14,7% en la privada. La tasa general de cesáreas fue del 48,1%, con un 31,4% en la maternidad pública y un 82,8% en la privada. La percepción de haber faltado el respeto, maltratada o humillada se dio en el 12,5% de las mujeres entrevistadas: un 14,9% en la maternidad pública y un 7,5% en la privada. En cuanto a las buenas prácticas de asistencia, el fomento de tener un acompañante, la oferta de líquidos y alimentos, el estímulo a la movilidad durante el trabajo de parto, la percepción de haber sido acogida en la maternidad y el contacto piel a piel fueron más frecuentes en la maternidad pública. Por otro lado, el sentimiento de estar cómoda para hacer preguntas y participar en las decisiones fue más frecuente en la maternidad privada. **Conclusiones:** Es frecuente la aplicación de prácticas no recomendadas de rutina en la asistencia al parto en ambas maternidades. La maternidad pública presentó una mayor prevalencia de buenas prácticas en comparación con la privada. La prevalencia de prácticas no recomendadas es superior a la prevalencia de haber sufrido falta de respeto, humillación o maltrato en el parto, según la percepción de las puérperas, lo que sugiere un escaso reconocimiento por parte de las mujeres de situaciones de violencia. En este escenario, la atención prenatal es un espacio para el intercambio de información sobre buenas prácticas y el reconocimiento de prácticas consideradas violencia obstétrica.

Palabras clave: Violencia obstétrica; Atención integral de salud; Parto.

INTRODUCTION

Quality care during pregnancy, childbirth and the postpartum period remains a global goal, because of the high rates of maternal morbidity and mortality and situations of neglect, abuse and disrespect in obstetric care.[1] Mistreatment during childbirth is considered a public health problem[2] and has received greater recognition from the World Health Organization (WHO) in recent decades, with the publication of

the documents “Intrapartum care for a positive childbirth experience” and “Prevention and elimination of disrespect and abuse during childbirth”.[1,3] These documents point out the various forms of violations of women’s rights and the use of poor care practices in maternity hospitals.[1,3]

The term “obstetric violence” (OV) is used to refer to any type of violation of physical, sexual or psychological integrity in obstetric care. It can occur in a context of discrimination, for example, according to socioeconomic class, ethnic-racial group and health condition, among other situations.[4] OV also manifests itself in a scenario of unindicated, uninformed and/or non-consensual practices, often for training purposes, such as in teaching hospitals, where multiple unnecessary vaginal examinations are common, for example.[2] For this study, the terminology OV was used to refer to the mistreatment, abuse and disrespect suffered by women during labor and delivery, by health professionals, also expressed in non-recommended practices, without scientific evidence of their benefits or potentially harmful, such as the pressure maneuver on the uterine fundus (Kristeller) and procedures performed without consent.

The term OV was created in Venezuela and is currently used throughout Latin America, being adopted by social movements, the academic community, professional associations and people with political activity, committed to the fight for women’s sexual and reproductive rights. Movements such as the Network for the Humanization of Childbirth and Birth, founded in 1993 in Brazil,[5] have driven legal changes in obstetric care, such as the companion law in 2005[6] and transparency in the cesarean section rate of each maternity hospital/obstetrician in 2015.[7] The use of the terminology “obstetric violence”, despite dividing opinions among the various obstetric care societies, and by the Ministry of Health, allows the recognition of an important problem in the scenario of obstetric care at a national level and highlights this specific type of gender violence that is still so present in Brazilian maternity hospitals.[8-10]

Instruments that assess women’s perceptions of having suffered OV show that the prevalence of the phenomenon is around 20% worldwide.[11-14] When the instrument is designed to measure OV through non-recommended practices, this prevalence is much higher, ranging from 78 to 98%.[12,15] A study conducted in North Brazil found that 87% of parturients who had a vaginal birth suffered at least some type of unnecessary intervention, according to WHO recommendations.[16] In this study, the authors considered that any incompatibility with the recommendations would already characterize a situation of violence in childbirth care.[16]

The different definitions of OV used in studies, both nationally and internationally, result in the wide variation in the prevalence found. Freedman et al., for example, propose understanding OV at different levels (Chart 1).[17] Less broadly, there are behaviors that are unanimously identified as disrespectful and abusive. Furthermore, there are practices that tend to be naturalized: behaviors that women in labor consider disrespectful or abusive, but health professionals do not; and those that women see as normal, but the scientific community, health regulatory bodies and organized societies consider violent. Likewise, negative experiences due to deficiencies in the health system can be condemned by women and professionals or be normalized.[17] Chart 1 presents situations and behaviors that deviate from quality, humanization and/or human rights practices.

In Brazil, the culture and organization of health systems are favorable to interventionist obstetrics. Births occur mostly in tertiary hospitals and are attended almost exclusively by physicians. With few exceptions, even in low-risk births, obstetric nurses or midwives do not actively participate.[20] Furthermore, women themselves lack the empowerment to demand active participation and decision-making in their births, whether due to incomplete or failed prenatal care, low education or little access to information and knowledge of their rights.[19]

Chart 1. Understanding obstetric violence at different levels.

Levels of disqualification of care (obstetric violence)	Examples of behaviors and practices
Treatments considered unanimously disrespectful and/or abusive	Physical abuse, sexual abuse and defamation.
Normalized behaviors: By the health professional, but condemned by the parturient By the parturient, but condemned by others	Depends on the local culture, the individual and the level of education: 1. Repeated and unnecessary vaginal examinations; use of forceps or other interventions, when not indicated, to speed up labor. 2. Treatment methods that are common in the culture, and therefore known and already accepted as possible treatment, such as the lithotomy position and episiotomy without precise indication.
Inadequate treatment due to structural deficiencies	Few resources for non-pharmacological pain management; impossibility of anesthetic management due to lack of trained professionals; limited physical space (preventing free movement and privacy); incompatibility between the number of women in labor and the number of professionals.
Deviations from national standards of quality of childbirth care	In Brazil, failure to comply with the law on companions or preventing breastfeeding in the first hour of the newborn's life, for women who wish to breastfeed.
Deviations from international standards of quality in childbirth care/human rights	Non-compliance with WHO recommendations: impossibility of choosing the birthing position, not being able to feed and move freely during labor.

WHO: World Health Organization.
Source: adapted from Freedman et al.,[17] with examples of Bowser and Hill[18] and Tesser et al.[19]

The disqualification of childbirth care often produces situations of OV related to limitations of the health system, the interventionist obstetric culture, the insufficiency of public policies, the lack of information among women and society regarding their rights and good practices in childbirth care, among other issues. This study aimed to identify the prevalence of recommended and non-recommended practices in childbirth care, according to the WHO, as well as women's perceptions of experiencing situations of disrespect, mistreatment or humiliation during childbirth, to encourage critical reflection on women's recognition of OV.

METHODS

Study design and population

A cross-sectional study was conducted with postpartum women who gave birth in two large maternity hospitals (one public and one private) in Porto Alegre, Rio Grande do Sul (RS), Brazil. The women were randomly selected by lottery from these services, which accounted for approximately 25% of the 30,268 births that occurred in the capital of Rio Grande do Sul in 2016. All women living in Porto Alegre who gave birth to a full-term newborn in the two participating maternity hospitals were eligible. Women or newborns with unfavorable outcomes at the time of delivery (death or hospitalization in intensive care) or who had contraindications for breastfeeding were excluded from the study, to avoid bias in the measurement of OV and other outcomes of interest in the research that originated this study.[21,22] Women living in areas at risk for home visits (defined as areas where visits by community health agents were suspended) were also excluded, to preserve the safety of the research team.

Collection of data

This study was conducted based on a survey whose main objective was to assess women's satisfaction with childbirth care. The sample size calculation used considered a significance level of 5% and a test power of 80%. The estimated sample size from the calculation was 276 women.[21] Data collection took place between January and August 2016. Every day, all women who had given birth in the previous 24 hours and who met the inclusion criteria received a number, which was used for the draw. Two women per day were included in the study in the public maternity ward and one in the private maternity ward, until the desired sample was reached. This proportion aimed to ensure representativeness in relation to the use of public and private services in Brazil, described in the literature as being approximately 70 and 30%, respectively.[23,24]

Between 30 and 37 days after delivery, an interview was conducted at the woman's home or, rarely, at another location preferred by the woman, to administer a structured questionnaire, which was prepared specifically for this study, based on the researchers' previous experience and on the guiding documents for childbirth care in Brazil.[25,26] Information regarding age, skin color and education were collected from the medical records of the selected women, before the inclusion criteria were assessed. Women who could not be reached for the interview after at least three attempts to contact them by telephone and one in person were considered losses.

The interviews were conducted after a pilot project that indicated the need for small semantic adjustments to the questionnaire. The field team consisted of 12 interviewers trained for the role. Weekly meetings were held with the field team, seeking greater uniformity in data collection.

Variables and statistical aspects

The variables used in this study (sociodemographic, obstetric and childbirth care) were systematized and analyzed using SPSS 21 software. The sociodemographic variables included were: age, skin color (self-reported), education, marital status, occupation and socioeconomic level. Socioeconomic status followed the classification criteria of the Brazilian Association of Research Companies (ABEP).[27] The variables related to women's health and obstetric issues were: current or past mental health problems, parity, having gone into labor, route of delivery, interventions and good practices applied during childbirth. Each practice was asked separately, one by one, during the interview with the women. Then, considering the WHO recommendations for childbirth care,[1] these practices were classified as non-recommended interventions (those in which there is no indication in any context, such as pressure maneuver on the uterine fundus, trichotomy and enema), not routinely recommended (those that may be indicated in specific situations, such as amniotomy, episiotomy, use of oxytocin, forceps and lithotomy position) and good practices in childbirth care (encouragement to have a companion, to have felt comfortable asking questions and participating in decisions, to have privacy, to have felt welcomed, to have felt safe, to have understood the information, encouragement to walk, having food and liquids offered, choice of birth position, use of analgesia, delayed clamping of the cord, skin-to-skin contact, newborn (NB) placed to breastfeed in the first hour of life and the woman having been informed about the reason for separation, in case the NB needed care and was removed from her). The respective absolute and relative frequencies were calculated for each categorical variable. Bivariate analysis was performed using Fisher's exact test and χ^2test.

To assess the woman's perception of having suffered disrespect, mistreatment or humiliation during childbirth, the following question was used: "Did you ever feel disrespected, humiliated or mistreated by health professionals?", with the following answer options: "Yes", "No" and "I don't know/I don't remember". The answer "Yes" to this question was understood as a clear perception of OV.

Ethical aspects

This study complies with the standards governing research involving human beings and was approved by the research ethics committees (CEP) of the institutions involved (CAAE 49938015.3.0000.5327 and 46775115.0.3002.5330).[28] All postpartum women who agreed to participate in the study signed an informed consent form.

RESULTS

Among the selected puerperal women (n=503), 379 were eligible. Of these, 287 were effectively interviewed. There were 25 (6.6%) refusals, and 67 women (17.7%) were lost due to failure to contact them to schedule the interviews. The women who were not interviewed differed in two aspects in relation to those who were interviewed: they had lower levels of education ($p<0.01$) and a higher prevalence of white skin color ($p=0.03$). Table 1 presents the sociodemographic and obstetric characteristics of the women interviewed, according to the service where they were seen. The women in the public maternity hospitals were mostly young (under 34 years old), belonged to socioeconomic classes C, D or E, were black or mixed race and had completed primary or secondary education, while the women in the private maternity hospitals were generally over 35 years old, had previously entered higher education and belonged to socioeconomic classes A or B. The overall cesarean section rate was 48.1%; however, among women who gave birth in the private maternity hospitals, this proportion reached 82.8%. Table 2 shows the prevalence of non-recommended and not routinely recommended interventions in childbirth care in the maternity hospitals under study.

The use of oxytocin to induce or accelerate labor was the most prevalent not routinely recommended intervention (56%), followed by amniotomy (48.5%) and episiotomy (37.1%). The fundal pressure maneuver (Kristeller) was performed in 11.3% of all deliveries; when stratified by maternity hospital, the prevalence was 25.7% in private hospitals and 8.2% in public hospitals. Amniotomy occurred in 48.5% of deliveries, 55.4% of those performed in public hospitals and 14.7% in private hospitals. Only the fundal pressure maneuver and amniotomy interventions differed in the studied maternity hospitals in a statistically significant way. The perception of having been disrespected, mistreated or humiliated occurred for 12.5% of the women interviewed: 14.9% in the public maternity hospital and 7.5% in the private maternity hospital, but without a statistically significant difference. Regarding good practices in obstetric care (Table 3), 90.1% of the women were encouraged to have a companion during labor, 78.3% felt fully welcomed, and 55.4% were offered liquids and light foods during labor. Encouragement to move around during labor occurred for 43.1% of the parturients, and skin-to-skin contact with the baby immediately after birth was provided for 59.4%. These practices had a significant difference in their occurrence between the public and private maternity hospitals, being more frequently applied in the public maternity hospital. The feeling of being comfortable to ask questions and participate in decisions was significantly more frequent in the private maternity hospital.

Table 1. Sociodemographic and obstetric characteristics of women in maternity hospitals in Porto Alegre, Rio Grande do Sul.

Sociodemographic characteristics	Total sample (n=287)	Public maternity hospital n=194 (67.6)	Private maternity hospital n=93 (32.4)	p-value**
	n (%)	n (%)	n (%)	
Age (years)				
≤19	23 (8.0)	23 (11.9)	00 (0.0)	
20–34	199 (69.3)	149 (76.8)	50 (53.8)	**<0.001**
≥35	65 (22.6)	22 (11.3)	43 (46.2)	
Skin color				
White	216 (75.3)	131 (32.5)	85 (91.4)	**<0.001**
Black/Brown	71 (24.7)	63 (67.5)	8 (8.6)	
Socioeconomic level (n=285)				
A-B	163 (57.2)	72 (37.5)	91 (97.8)	**<0.001**
C-D-E	122 (42.8)	120 (62.5)	2 (2.2)	
Education				
Elementary or secondary	163 (56.8)	160 (85.5)	3 (3.2)	**<0.001**
Higher education*	124 (43.2)	34 (17.5)	90 (96.8)	
Lives with partner				
Yes	247 (86.1)	158 (81.4)	89 (95.7)	**0.001**
No	40 (13.9)	36 (18.6)	4 (4.3)	
Work situation when pregnant (n=274)				
Working	207 (75.5)	126 (68.1)	81 (75.5)	**<0.001**
Not working	67 (24.5)	59 (31.9)	8 (24.5)	
Mental health problems				
Current or past	38 (13.2)	23 (11.9)	15 (16.1)	0.354
No	249 (86.8)	171 (88.1)	78 (83.9)	
Parity (n=286)				
Primiparous	142 (49.7)	84 (43.5)	58 (62.4)	**0.004**
Multiparous	144 (50.3)	109 (56.5)	35 (37.6)	
Delivery route				
Vaginal	149 (51.9)	133 (68.6)	16 (17.2)	**<0.001**
Cesarean	138 (48.1)	61 (31.4)	77 (82.8)	
Went into labor				
Yes	205 (71.4)	169 (87.1)	36 (38.7)	**<0.001**
No	82 (28.6)	25 (12.9)	57 (61.3)	

*Complete or incomplete; **p-value referring to bivariate analysis (Fisher's exact test and χ^2 test.

DISCUSSION

The most prevalent not routinely recommended interventions in this study were the use of oxytocin (56%), amniotomy (48.5%) and episiotomy (37.1%). The fundal pressure maneuver was performed in 11.3% of deliveries, with greater frequency in private maternity hospitals. Amniotomy was more frequent in public maternity hospitals (55.4%) compared to private maternity hospitals (14.7%). The overall cesarean section rate

Table 2. Prevalence of non-recommended and non-recommended routine interventions during labor in maternity hospitals in Porto Alegre, Rio Grande do Sul.

Non-recommended interventions	Total sample (n=287)	Public maternity hospital n=194 (67.6)	Private maternity hospital n=93 (32.4)	p-value*
	n (%)	n (%)	n (%)	
Non-recommended interventions				
Trichotomy (n=202)				
Yes	12 (5.9)	8 (4.8)	4 (11.4)	0.228
No	190 (94.1)	159 (95.2)	31 (88.6)	
Enema (n=203)				
Yes	7 (3.4)	4 (2.4)	3 (8.6)	0.100
No	196 (96.6)	164 (97.6)	32 (91.8)	
Kristeller maneuver (n=194)				
Yes	22 (11.3)	13 (8.2)	9 (25.7)	**0.007**
No	172 (88.7)	146 (91.8)	26 (74.3)	
Non-recommended routine interventions				
Amniotomy (n=200)				
Yes	97 (48.5)	92 (55.4)	5 (14.7)	**<0.001**
No	103 (51.5)	74 (44.6)	29 (85.3)	
Use of oxytocin to induce or accelerate labor (n=193)				
Yes	108 (56.0)	94 (58.8)	14 (42.2)	0.123
No	85 (44.0)	66 (41.3)	19 (57.6)	
Episiotomy (n=194)				
Yes	72 (37.1)	64 (39.8)	8 (24.2)	0.114
No	122 (62.9)	97 (60.2)	25 (75.8)	
Forceps (n=195)				
Yes	11 (5.6)	7 (4.4)	4 (11.4)	0.113
No	184 (94.4)	153 (95.6)	31 (88.6)	
Lithotomy (n=151)				
Yes	150 (99.3)	134 (99.3)	16 (100)	1.000
No	1 (0.7)	1 (0.7)	0 (0.0)	
Perception of disrespect. mistreatment or humiliation during childbirth (obstetric violence)				
Yes	36 (12.5)	29 (14.9)	7 (7.5)	0.088
No	251 (87.5)	165 (81.1)	86 (92.5)	

*p-value referring to bivariate analysis (Fisher's exact test).

was 48.1%, with 31.4% in public maternity hospitals and 82.8% in private maternity hospitals. The perception of having been disrespected, mistreated or humiliated occurred for 12.5% of the women interviewed: 14.9% in public maternity hospitals and 7.5% in private maternity hospitals. Interventionism during childbirth is not exclusive to the maternity hospitals included in this study. Other surveys, conducted both in Brazil and internationally, indicate frequencies of mistreatment during childbirth similar to those found in the present study (11.3%, 8.2% in the public system and 25.7% in the private system), with a prevalence of pressure maneuvers on the uterine fundus ranging from 16[20] to 37%,[29] despite it being a prohibited practice, due to its association with higher rates of hospitalization of newborns in the intensive care unit (ICU) and perineal laceration.[30]

Table 3. Prevalence of good practices during labor and birth in maternity hospitals in Porto Alegre, Rio Grande do Sul.

Good practices in childbirth	Sample (n=287)	Public maternity hospital n=194 (67.6)	Private maternity hospital n=93 (32.4)	p-value**
	n (%)	n (%)	n (%)	
Encouraged to have a companion present (n=284)				
Yes	256 (90.1)	181 (93.8)	75 (82.4)	**0.005**
No	28 (9.9)	12 (6.2)	16 (17.6)	
Had a companion at all times (n=187)				
Yes	162 (91.3)	173 (89.2)	89 (95.7)	0.076
No	25 (8.7)	21 (10.8)	4 (4.3)	
Felt comfortable asking questions and participating in decisions (n=283)				
Yes, fully	240 (84.8)	157 (81.8)	83 (91.2)	**0.050**
No, or not enough	43 (15.2)	35 (18.2)	8 (8.8)	
Had privacy (n=280)				
Yes, fully	235 (83.9)	157 (83.1)	78 (85.7)	0.608
No, or too Little	45 (16.1)	32 (16.9)	13 (14.3)	
Felt welcomed (n=281)				
Yes, fully	220 (78.3)	155 (82.4)	65 (69.9)	**0.021**
Little, or insufficient	61 (21.7)	33 (17.6)	28 (30.1)	
Felt safe (n=282)				
Yes, fully	209 (74.1)	141 (74.6)	68 (73.1)	0.775
Little, or insufficient	73 (25.9)	48 (25.4)	25 (26.9)	
Understood the information given by the professionals				
Yes, fully	251 (87.5)	167 (86.1)	84 (90.3)	0.347
No, or not all	36 (12.5)	27 (13.9)	9 (9.7)	
Liquids and light food were offered (n=204)				
Yes	113 (55.4)	108 (64.3)	5 (13.9)	**<0.001**
No	91 (44.6)	60 (35.7)	31 (86.1)	
Encouraged to move around (n=204)				
Yes	88 (43.1)	83 (49.1)	5 (14.3)	**<0.001**
No	116 (56.9)	86 (50.1)	30 (85.7)	
Chose the birthing position (n=151)				
Yes	13 (8.6)	12 (8.9)	1 (6.3)	1.000
No	138 (91.4)	123 (91.1)	15 (93.8)	
Pain relief methods were used* (n=205)				
Yes	164 (80.0)	138 (81.7)	26 (72.2)	0.250
No	41 (20.0)	31 (19.3)	10 (27.8)	
Delayed cord clamping (n=217)				
Yes	92 (42.4)	60 (39.0)	32 (50.8)	0.131
No	125 (57.6)	94 (61.0)	31 (49.2)	
If NB was removed from mother, the reason was explained (n=265)				
Yes	209 (78.9)	144 (81.8)	65 (73.0)	0.112
No	56 (21.1)	32 (18.2)	24 (27.0)	
Had skin-to-skin contact in the delivery room (n=281)				
Yes, immediate	167 (59.4)	130 (68.4)	37 (40.7)	
After procedures	24 (8.5)	19 (10.0)	5 (5.5)	**<0.001**
No	90 (32.0)	41 (21.6)	49 (53.8)	
NB placed to breastfeed in the first hour of life (n=284)				
Yes	189 (66.5)	129 (67.5)	60 (64.5)	0.688
No	95 (33.5)	62 (32.5)	33 (35.5)	

NB: newborn; *pharmacological or non-pharmacological methods; **p-value referring to bivariate analysis (Fisher's exact test and χ^2 test).

Strict protocol routines are also characteristic of maternity hospitals. In a representative study of the Brazilian population published in 2014, it was found that 91% of births in the public health system and 89% of births in the private health system occurred in the lithotomy position.[29] In the present study, 91% of women stated that they had not chosen the birth position, and practically all women who had a vaginal birth gave birth in the lithotomy position, despite evidence showing that upright positions are associated with shorter labor time, less intense pain, less use of interventions, and greater satisfaction with the birth experience.[31]

Episiotomy is a practice applied exclusively to women who have vaginal births, in which an incision is made in the perineum with the supposed purpose of aiding the passage of the fetus. This practice is recognized by some authors as a modern genital mutilation[32] which, in addition to having no well-established evidence of benefits, when poorly indicated is associated with third and fourth degree perineal lacerations, hemorrhage and infection.[33] Studies carried out in Brazil show a tendency for this practice to decrease in maternity hospitals: in 2014, the prevalence was 47% and 67% in the public and private sectors,[29] respectively; and in 2017, it was 28% in the public sector and 39% in the private sector,[20] a prevalence very similar to that found in the present study, which identified an overall frequency of 37.1%: 24.2% in the public maternity hospital and 39.8% in the private maternity hospital.

Brazil has one of the highest cesarean section rates in the world: 56% in 2016.[34] Considering only the supplementary health system (health insurance and private financing), the rates rise to 85%.[34] The present study identified an overall prevalence of cesarean sections of 48%, a percentage well above that recommended by the WHO, which is a maximum of 15%.[35,36] Although cesarean sections have revolutionized obstetrics, saving lives in well-indicated cases, they present more risks to the woman and the newborn when compared to the vaginal route of birth, such as increased need for admission to the ICU for the woman and the newborn, use of antibiotics, blood transfusions and hysterectomy.[37,38] Therefore, cesarean sections, when not well indicated for maternal or fetal reasons, are a factor in increasing maternal and infant morbidity and mortality.[39]

This study allows us to identify that the high prevalence of unnecessary practices, without scientific evidence of benefits and, at times, harmful to women, is not compatible with the prevalence of perception of disrespect, mistreatment and humiliation reported by women. This aspect suggests that women do not recognize situations considered violent according to the definitions supported by official bodies, such as the WHO[1] and the Ministry of Health,[26] as well as by the scientific community.[40] It is assumed that women who are aware of their rights and have knowledge of good practices in childbirth care would be able to identify non-recommended attitudes and interventions, which seem to have become naturalized, as shown by the findings of this study. In this context, prenatal care provided in primary health care (PHC)[21] can be an important space for women to be equipped to recognize their rights during childbirth, to learn about practices that are beneficial to the mother and baby, such as birth position, movement, intake of water and soft foods, as well as avoiding not routinely recommended practices. OV directly affects women's rights as citizens[2] and has short- and long-term impacts on both the woman and the newborn,[2] the family and society, such as postpartum depression.[41] Women who are victims of abuse during childbirth have a higher risk of developing post-traumatic stress and depression, problems that, in addition to affecting their psychological health, interfere with their relationship with the baby.[42] Children of women with postpartum depression have a higher risk of presenting cognitive, emotional and psychological problems in adulthood.[43] Therefore, combating OV in maternity wards has an important social impact.

The prevalence of disrespect, mistreatment or humiliation during childbirth, according to the perception of the women who participated in this study, appears to be higher in public maternity hospitals when compared to private maternity hospitals. The higher frequency of OV in the public institution, although not statistically significant, may have occurred possibly because of the fact that, in this service, 87.1% of the women went into labor, while in the private institution, only 38.7% experienced this experience. In the context of obstetric care in most Brazilian maternity hospitals, going into labor means being exposed to several interventions, often painful, unnecessary and without scientific evidence to justify their application.[29] Another aspect to be considered is the fact that scheduled cesarean section is a choice (largely influenced by the obstetrician's preference) of women coming from the private system, an option not available in the public system, in a country where surgical delivery has an important symbolism of social status.[44]

Regarding good practices in obstetric care, women who gave birth in public maternity hospitals felt more welcomed, were more encouraged to eat light foods and liquids and to move around during labor. This was possibly due to the fact that a greater number of women in public maternity hospitals went into labor. Strategies that provide greater safety, strength and autonomy for women, such as movement during childbirth, in addition to reducing the duration of the first stage of labor, also reduce the need for cesarean sections and epidural anesthesia, and are also a manifestation of respect for women's autonomy.[45,46] In public institutions, women were more encouraged to have a companion, a right guaranteed by law[6] and associated with shorter labor, reduced rates of cesarean sections, instrumental vaginal deliveries, use of analgesia and risk of suffering from oral incontinence.[47] Having a companion during childbirth protects women from situations of violence and provides a better childbirth experience and, consequently, greater satisfaction with the care received.[48,49] The Nascer no Brasil study found that 80.7% of women did not have a companion at some point during childbirth,[49] an aspect that highlights the gap between the right guaranteed by law for almost two decades and what is effectively carried out in practice.

Another good practice, of important benefit to mother and baby, is skin-to-skin contact, recognized for preventing hypothermia and promoting breastfeeding.[50] Skin-to-skin contact was performed in just over half of the pairs in this study, a percentage much higher than that found in another national study (34%), but still infrequent, considering the benefits of this low-cost and easy-to-apply practice.[51]

In this scenario, solidifying prenatal care as a tool for guiding women and their partners to combat OV and encourage good practices in childbirth care can be effective, since this monitoring is longitudinal and allows for the establishment of a bond with the pregnant woman and her partner. The birth plan can be the materialization of the construction carried out jointly between the professional, pregnant woman and partner throughout the prenatal period, an instrument that empowers women and expresses their choices in a clear and documented manner, providing a space for education, listening and dialogue about childbirth care practices. Another aspect that deserves to be highlighted is the importance of avoiding gaps in the continuity of care, in the context of the transition between primary care and maternity. If the work carried out with pregnant women in primary care, including the creation of a birth plan, is aligned with the care practices of the reference maternity hospital, it is believed that the chances of a positive birth experience increase, based on studies on the continuity of interpersonal relationships during this period.[52] Organizing groups for pregnant women and guided visits to the reference maternity hospital are possibilities that can facilitate this transition. This study was conducted with methodological rigor and continuous quality control (regular meetings with the interviewers, verification of key questions with 5% of the sample). The interviews were conducted face-to-face, which ensures greater quality of the data collected. The information from this study provides support for qualifying obstetric care, proposing continuing education activities for teams working in prenatal and childbirth care, and developing public policies to combat violations of women's rights.

Among the limitations, it should be considered that the data were collected in 2016, and that 2018 guidelines were used to evaluate recommendations for childbirth care practices. Other limitations of this study include the number of losses, the exclusion of women living in high-risk areas — possibly more vulnerable and exposed to violent practices — and the sample size, which may have limited the power to verify some associations.

CONCLUSION

This study shows the differences between women who use public and private maternity hospitals in Porto Alegre (RS), in terms of sociodemographic, obstetric and, above all, healthcare characteristics. Most women in the public health system went into labor and had vaginal deliveries, while women in the private system mostly had previously scheduled surgical deliveries. Both public and private maternity hospitals had high prevalence of routine practices that were not recommended, according to the WHO. The public maternity hospital had a higher prevalence of good practices in childbirth care.

The findings highlight the gap between women's perception of having suffered OV and what is considered the definition of this phenomenon, according to technical and scientific publications. Women exposed to unnecessary, obsolete and painful practices often do not identify them as violent. Caesarean sections were more frequent in the private maternity hospital, while vaginal deliveries were more frequent in the public maternity hospital. Since the type of delivery directly affects women's exposure to a greater number of care practices, women in the public system experienced a higher prevalence of good practices compared to those in the private system. Unrecommended practices were frequent in both maternity hospitals.

PHC plays an important role in providing pregnant women with tools about their rights during childbirth, identifying violent and unnecessary practices, and encouraging them to learn about good practices so that, above all, they can have positive experiences. Respect, acceptance, and the application of practices based on scientific evidence are women's rights and are the commitment of all professionals who accompany them during the pregnancy-puerperal cycle. The shared use of a birth plan and improving continuity of care between primary care and maternity care are examples of strategies that can contribute to more qualified care focused on pregnant women.

AKNOWLEDGMENTS

The authors thank the following: the Federal University of Rio Grande do Sul, the institution with which the researchers are affiliated; the National Council for Scientific and Technological Development (CNPq) for funding the research; and all the women who took part in this study.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

JCP: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Resources, Software, Writing – original draft, Writing – review & editing. ASS: Conceptualization, Data curation,

Formal analysis, Investigation, Methodology, Resources, Software, Validation, Writing – original draft, Writing – review & editing. ACMM: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Resources, Software, Validation, Writing – original draft, Writing – review & editing. SMSA: Formal Analysis, Investigation, Methodology, Resources, Software, Writing – original draft, Writing – review & editing. MB: Formal analysis, Investigation, Methodology, Writing – original draft, Writing – review & editing. CG: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Validation, Writing – original draft, Writing – review & editing.

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