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Obstetrical Violence: Struggle in Labor Humanization Obstetrical Violence

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Abstract: *Introduction: Labor Humanization is the group of actions performed by health professionals while respecting the physiology of women, without unnecessary interventions. Interventions in which there is an appropriation of the body and the reproductive processes, and are expressed in dehumanizing acts, abuse of medicalization and pathologiziation of the natural processes, limiting women's role in parturition, those acts configure obstetric violence. OBJECTIVE: To contribute to the knowledge on obstetric violence by analyzing the bibliographical production in order to have a positive influence in interpersonal relationships of professionals working in obstetrics. METHODOLOGY: Integrative literature review of the articles published in the period from 2010 to 2014 in the databases MEDLINE, LILACS, SciELO, BDENF and PubMed. RESULTS: After reading the title and abstract of 1,372 articles, 34 possibly addressed the topic were read, of these, 10 were selected. It was observed that the harmful practices, ineffective acts or improper uses addressed in the studies were: enema, shaving, oxytocin administration, lithotomy position, prophylactic catheterization, uterine review, epidural, cesarean section, episiotomy and water and food restriction. Being the most frequent the use of oxytocin and episiotomy. CONCLUSION: The practice classified as harmful or ineffective and used inappropriately, unfortunately, still strongly present in the obstetric routine in several institutions. In addition, the scientific literature on the subject is still scarce and there is no specific law governing acts of obstetric violence.*

Keywords: *Obstetric violence. Humanized delivery. Violence against women. Labor.*

1. INTRODUCTION

Social and technological changes in recent decades have determined important changes in labor care model and childbirth[1]. Since childbirth came to be performed in the hospital it suffered major changes from its assistance and the paradigm of the way of care. In that sense numerous interventions seen as beneficial were adopted over the years, although some of these interventions are not the best for the woman and the newborn[2].

This new contemporary setting of delivery certainly changed and interfered with woman-baby-family interpersonal bond and in health care relationships, shifting the main role to the health team rather than the woman and the family. On the other hand, this process was crucial for the appropriation of medical knowledge and access to health care technologies[1,2].

In developed countries and many developing countries, most births are performed by doctors in hospitals. In Brazil, the current model of obstetric care is characterized by excessive use of technologies, medicalization and invasive procedures. Seeking to change this reality, the childbirth humanization aims to ensure assistance based on scientific evidence and patient safety rather than favoring the institutions or professionals[3].

The humanization of childbirth care considers that health professionals should act respecting the physiology of women, without unnecessary interventions, recognizing the social and cultural aspects

of labor and birth and provide emotional support to women and their families, ensuring family bonding and the mother-child link[1].

In this context, the appropriation of the body and reproductive processes of women, is expressed by dehumanizing acts, abuse of medications and making pathological the natural processes, generating loss of the patient's autonomy and ability to decide about their body and their sexuality, characterizing obstetric violence (OV)[4].

In Venezuela this type of violence is recognized as a crime and it must be prevented, punished, and eradicated. In 2006, it was approved the "Organic law on the right of women for a life free of violence" ("Ley organica sobre el derecho de las mujeres a una vida libre de violencia") which establishes fines and disciplinary actions against those who commit such violence[4].

In Brazil there is still no specific law to punish OV, and the legal support is borne by the Brazilian penal code based on ordinance No. 569 of June 1, 2000, of the Ministry of Health (MH), which states that every pregnant woman is entitled to have access to the healthcare system and have decent and qualified care during pregnancy, childbirth and postpartum in a humane and secure manner[5].

In 1996, concerned about the growing interference in the natural act of giving birth, the World Health Organization (WHO) published the guide "Care in normal birth: a practical guide", an important bibliographic reference on assistance provided to women during labor, later incorporated by the Brazilian MH. Based on scientific evidences, the obstetric practices were classified on a scale that demonstrates practices that should be encouraged and others that should be abolished[6].

In this classification stands out the harmful practices that must be eliminated such as enema (intestinal lavage), shaving of the pubic hair, intravenous infusion (saline solution to "get a vein"), rectal examination, administration of oxytocin to speed up labor, lithotomy (gynecological position) or supine position (lying on back), asking woman to push; and the practices that might be useful, but are often used improperly including: fluid and food restriction, pain control by systemic agents or epidural anesthesia, repeated vaginal examinations, operative delivery (cesarean), episiotomy (cutting and suturing the vaginal area), manual exploration of the uterus, among others[3,6].

Given the above, this study aims to contribute to the knowledge in this area by analyzing the bibliographical production on obstetric violence, and to recognize the main practices considered harmful, ineffective or used improperly during labor.

2. METHODOLOGY

Systematic review of obstetric practices considered harmful, ineffective or used improperly according to the classification of common practices in natural birth[6].

The search strategy occurred through isolated consultation on the website of the Brazilian Virtual Health Library "Biblioteca Virtual em Saúde (BVS)" with a selection of articles indexed in the databases LILACS, MEDLINE and BDENF Nursing. Subsequently it was followed with search in SciELO and PubMed websites.

The inclusion criterion was published literature from 2010 to 2014, without language distinction, found from the descriptors: obstetric violence, humanizing delivery, labor and violence against women, searched in Portuguese and English. The descriptor "violência obstétrica" and its corresponding in English "obstetric violence" were not found in the list of Descriptors in Health Sciences (DeCS) and the Medical Subject Headings (MeSH). However, it was entered in the search strategy given to its relevance.

Exclusion criteria used were: studies that did not include the theme, review articles, course conclusion papers, qualitative studies and studies that described less than two interventions. When appeared duplicate studies it was considered the first database in which it was found.

Initially, the articles were selected for analysis of their title and / or summary. Then full-text articles that potentially addressed the topic were accessed.

3. RESULTS

Throughout the research, 1372 articles were located, being 461 in MEDLINE, 51 in LILACS and 91 in BDENF. In SciELO was found 254 articles, and 515 in PubMed. Of this total, 1338 were excluded by reading the title and / or summary or for not fitting the inclusion criteria. After evaluating the

remaining 34 articles in full, 24 were excluded for not describing obstetric practices. Thus, 10 articles were selected for this study (Figure1).

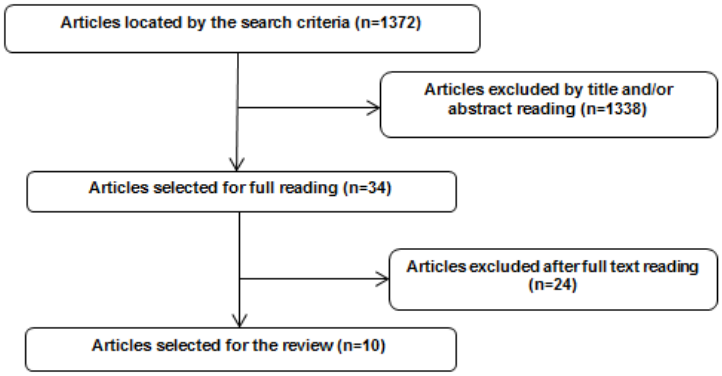

Figure1. *Flow chart of the selection of the articles included in the review process*

Of the ten selected studies, four were conducted with women in labor or postpartum (puerperium), one was conducted with health professionals working in obstetrics, three made through chart analysis, one researched health professionals and made analysis of medical records and the other with women in labor and medical records (Table 1).

Among the studies, the most frequent interventions were: administration of oxytocin and episiotomy (Table 2). Only two studies[7,8] described the practices according to WHO classification in the conduct of natural birth (NB), purpose of this review.

In a study conducted through interviews with health professionals of an obstetric center of a public teaching hospital in Rio Grande do Sul it was found that most pregnant teenagers received oxytocin infusion and had performed episiotomies routinely[9].

In a study conducted in the same state it was found that episiotomy was performed in most pregnant women, as well as the use of epidural analgesia, use of invasive devices, prophylactic catheterization, forceps and use of oxytocin. When interviewing professionals, the vast majority affirmed to adopt lithotomy position, make use of oxytocin, shaving and perform routine episiotomy[8].

Table1. *Location and composition of the studies included in the review (2010-2014).*

STUDY	LOCATION	SAMPLE	SAMPLE COMPOSITION
LEAL et al. (2014)	191 Cities in Brazil	23.894 women	Postpartum women of different ages
VOGT, SILVA E DIAS (2014)	Belo Horizonte, Minas Gerais, Brazil	655 women and data from medical records	Primiparous mothers of different ages
NEAL et al. (2014)	United States of America	216 women in labor	Pregnant women 19-32 years old
SILVA, R.C.et al. (2013)	Pelotas, Rio Grande do Sul, Brazil	48 health professionals	7 nurses, 12 nursing technicians, 12 nursing assistants, 10 medical staffs and 7 medical residents
TERÁN et al. (2013)	Caracas, Venezuela	425 postpartum women	Pregnant women 15-42 years old
SCHNECK et al. (2012)	Sao Paulo, Brazil	1.316 medical records	Pregnant women of different ages
VOGT et al. (2011)	Belo Horizonte, Minas Gerais, Brazil	831 medical records	Pregnant women 19-35 years old
GIGLIO, FRANÇA AND LAMOUNIER (2011)	Goiania, Goias, Brazil	404 medical records with partograph	Postpartum women with unspecified ages
MILFONT et al. (2011)	Morada Nova, Ceara, Brazil	21 women in labor	Pregnant women 21-27 years of life
BUSANELLO et al. (2011)	Rio Grande, Rio Grande do Sul, Brazil	23 health professionals and 128 medical records	4 nurses, 6 nursing technicians or nursing assistants, 6 medical staffs, 7 medical residents Pregnant teenagers

A study conducted in Venezuela found that 49.4% of mothers reported some kind of dehumanizing treatment, such as ironic and disqualifying comments, stop from changing positions and walking, criticism for crying or screaming, among others. These practices occurred more frequently in NB (46.2%) and pointed the nurse as responsible for most of them[10].

The research "Born in Brazil: national survey on labor and birth" coordinated by the Osvaldo Cruz Foundation, revealed alarming data. It was observed that most women either gave birth in lithotomy position, made use of peripheral venous catheter, received epidural analgesia, experienced episiotomy or cesarean delivery. There was also the use of oxytocin and food restriction, but at a lower rate. In this study, the vast majority of women who had vaginal delivery was subjected to excessive interventions and only 5% of them gave birth with no intervention[11].

High rates were also seen in a study involving 13 referral hospitals in low-risk delivery in the Brazilian Midwest. It was found that episiotomy occurred in 70.1% of births. Other practices such as shaving, saline infusion, diet restriction and use of oxytocin occurred in smaller percentages, but still worrisome[7].

A study in 2011 analyzing medical records of low-risk pregnant women showed the use of oxytocin, episiotomy, epidural analgesia and cesarean section. In this same review, only 15% of deliveries were performed without these interventions[12]. Later, in 2014, the same author and colleagues found the same practices but at a highest percentage. A study involving the collaborative model and the traditional method in delivery showed higher rates in four hospitals linked to the Unified Health System (SUS) in Brazil[13].

An observational study analyzing the practices of health care professionals to pregnant women in a maternity hospital in the Northeast of Brazil, found that all women were subjected to shaving and could not choose the position to give birth, depriving them of the "right to participate in decisions" about the delivery process[14].

Tabela 2. Práticas prejudiciais ou ineficazes ou usadas de modo inadequado identificadas nos estudos (2010-2014).

PRÁTICAS PREJUDICIAIS OU INEFICAZES OU USADAS DE MODO INADEQUADO	LEAL et al. (2014)	VOGT, SILVA E DIAS (2014)	NEAL et al. (2014)	SILVA, R. C. et al. (2013)	TERÁN et al. (2013)	SCHNECK et al. (2012)	VOGT et al. (2011)	MILFONT et al. (2011)	GIGLIO, FRANÇA E LAMOUNIER (2011)	BUSANELLO et al. (2011)
ENEMA OU ENTEROCLISMA				100%	1,2%				2,8%	4,3%
TRICOTOMIA				2,1%	1,2%			100%	41,1%	69,6%
ADMINISTRAÇÃO DE OCITÓCINA	36,4%	57,7%	45,1%	91,7%	31,3%	47,2%	43%		45,8%	13,3%
POSIÇÃO DE LITOTOMIA OU DECÚBITO DORSAL	91,7%			100%	24,9%			100%*		95,6%
CATETERIZAÇÃO PROFILÁTICA	74,9%								55,9%	10,9%**
REVISÃO UTERINA					14,1%					
ANALGESIA PERIDURAL	33,9%	38,9%	94,1%				31,1%		7,7%	18,7%
EXAMES VAGINAIS REPETIDOS			4,8%		37,2%				23%	
PARTO OPERATÓRIO(CESÁREA)	51,9%		6,9%		23,5%		3%			
EPISIOTOMIA	53,5%	49,4%		58,3%	20%	32,9%	25,6%		70,1%	46,1%
RESTRIÇÃO HÍDRICA E ALIMENTAR	74,8%			12%		13,3%			62%	21,7%

* Não puderam escolher a posição de parir.

**dispositivos invasivos como sondas vesicais, cateterização profilática de rotina ou fórceps conforme prontuários.

In another Brazilian study fewer interventions were observed in women that delivered at a birthing center compared to hospital care. In the birthing center, there were no dietary restrictions for almost all of the women (99.7%) and the number of episiotomy and oxytocin use was lower in relation to hospital care[15].

In this present review only one study was done at a developed country. The authors of the study evaluated interventions in primiparous women with low-risk pregnancy during hospitalization. It found that the admission before the active phase of labor increased the probability of use of oxytocin and cesarean section. The use of oxytocin had a big variation between the groups, pre-active phase (84.2%) and active phase (45.1%) of labor. However, the percentage of cesarean section was low in both groups, 15.8% and 6.9% respectively[16].

4. DISCUSSION

It was found an obstetric care model characterized by a high level of medicalization and invasive practices. Regarding harmful or inefficient practice, there is a wide range of prevalence. Percentages ranging from 1 to 100% were found, generally at high rates.

Humanizing delivery goes far beyond not using harmful practices. It is empowerment, guidance and respect to the parturient, as well as permission and encouragement for the presence of a companion of their choice.

It was found that during labor the lithotomy position or dorsal decubitus was almost as a rule in Brazilian maternity hospitals. Unfortunately, these results were also observed in other Brazilian studies in which 98.3% of women had delivered in lithotomy position and 79.6% remained in supine position throughout labor[17]. According to a meta-analysis involving 6,135 women, the use of any upright or lateral position compared with lithotomy position or dorsal decubitus in the second stage of labor is associated with the reduction of the duration, instrumentation, episiotomy rate, severe pain complains and fewer abnormalities in fetal heart rate patterns[18].

It is observed in recent years a tendency for not performing enema and shaving. However this is still performed under the allegation of reducing the risk of contamination by feces and puerperal infections. In a randomized clinical trial, was compared 90 women in labor with and without enteroclysis. The frequency of fecal contamination did not differ between groups and did not decrease delivery time[19]. A meta-analysis on the use of enema involving 1917 women concluded that this practice does not carry significant beneficial effect on infection rates or women's satisfaction, since it can cause discomfort[20].

The same is true regarding shaving, procedure said to reduce infection rates and facilitate perineal suturing in case of injuries (lacerations or episiotomies). Many women report that dislike the procedure for generating discomfort when the hair grows back[3]. However shaving is a common practice in Brazilian public hospitals and has high rates for both the normal labor (63.3 %) and for cesarean section (66.7 %)[17].

A meta-analysis involving 1,039 women with and without hair removal did not identify differences in perineal wound infection rates, dehiscence, neonatal infection or maternal satisfaction. However, side effects such as irritation, redness, itching and burning have been reported[21].

The administration of oxytocin also suffered variations in this review. In France, the use of oxytocin was also frequent. In 2010, 58% of women used oxytocin at the beginning of spontaneous delivery and 64% in the active phase, mainly those of low-risk pregnancy, nulliparous women, overweight and in small or private hospitals[22].

Prophylactic catheterization was less frequent in the reviewed studies, being venous catheterization performed the most. This practice makes it hard for women to make movements in bed or walk[17]. In a study conducted in Southern Brazil, 91.8% of teenagers in labor had catheterization performed on them, proving to be a routine practice[23].

Regarding the practices used improperly, episiotomy was the one with greater frequency. For this procedure, the WHO established an acceptable range around 10% of all births. However, it was observed that this procedure was performed routinely and indiscriminately[6]. In France episiotomy rates are much lower, performed only in 3.4% of vaginal deliveries. The guidelines of the French National College of Gynecologists and Obstetricians “Collège National des Gynécologues

Obstétriciens Français (CNGOF)" advocates a strict policy on episiotomy realization and states that the reduction of this practice does not increases the number of 3rd and 4th degree perineal laceration[24].

Alarming percentage was observed in a study conducted in Southern Brazil with adolescents assisted at a university hospital, in which 89.6% had their perineum cut during vaginal delivery[23]. Besides the aesthetic appearance changes, the episiotomy scar may generate perineal pain, even during sexual intercourse, changes in sensitivity and coloration of the skin, dehiscence of the wound, among other complications[9].

Regarding the type of delivery, the WHO recommends as acceptable a rate up to 15% for the realization of operative delivery. In the analyzed studies, this percentage ranged between 3% and 51%[6].

In 2007, a study on cesarean rates involving 126 countries showed a great variety of results. While in Latin America was observed high rate (29.2%), in Africa this number was much lower (3.5%). In developed regions, including Europe, North America, Japan, Australia and New Zealand, the rates ranged between 6.2% and 36%[25].

Brazil has the world's largest rate of caesarean section (52%). Of these, 46% realized in the public health system and 88% in the private system[11].

Another common practice is to restrict fluid and food intake during labor. This is due to the fear of stomach content aspiration during anesthesia induction[1]. In this review, this practice varied between 12% and 74%.

A meta-analysis involving 3,130 women concluded that there is no evidence to justify the food and fluid restriction during labor in women with low-risk pregnancy[26]. Severe restriction of oral ingestion, however, can lead to dehydration and ketosis[6].

Regarding the realization of repeated vaginal examinations by different professionals, epidural analgesia and review of the uterus, there was a low frequency in the analyzed studies, but with worrying rates as these techniques should be performed with caution.

The vaginal examination is an important practice to assess the start and progress of labor. It should be done only when there is real need, and limited to an examination every four hours during the first stage of labor[6]. Worrying data was found, 61% of women were subjected to frequent vaginal examinations, more than one exam being performed every hour, and only 0.5% of them every four hours[17].

The percentage of epidural analgesia found in this review was high and ranged between 7% and 94%. But in another study this practice rate was much lower, performed only in 3.1% of vaginal deliveries[17].

It is noteworthy that pain control can be achieved with adequate physical and emotional support only. In the Netherlands, a study with 1,511 women showed that most of them (85.5%) did not wish to receive drugs for pain relief during labor[27]. Non-pharmacological methods such as massages, bubble baths, active walking, breathing and relaxation techniques, comforting touch, use of birth balls should also be used for pain relief[1].

It's worth mentioning that obstetric interventions exists to save lives and, if well indicated, can contribute to the welfare of the mother and her baby. The indication of these procedures is sometimes necessary and does not mean demerit or lack of effort of the mother, the doctor or the team in general. However, unnecessary interventions or if used improperly can bring physical and psychological consequences for the rest of the patient's life.

5. CONCLUSION

This review concludes that scientific studies related to the theme obstetric violence is still scarce. And that the practices classified by the WHO as clearly harmful, ineffective or used improperly are still strongly present in the obstetric routine of several institutions.

There has been a broadening in the discussions on obstetric violence. Groups of victims, delivery humanization activists and non-governmental organizations (NGOs) are the ones to sponsor this debate in most cases. This dialogue shows to be imperative in order to mobilize society for the

importance of delivery humanization, especially because in Brazil there is still no specific law to regulate obstetric violence, leaving it to isolated cases in court.

CONTRIBUTORS

Nívea Adriano de Santana and Santos drafted the first version of the text and participated in all subsequent steps.

Maria Vieira de Lima Santrain participated in the preparation and review of all versions.

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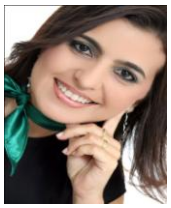

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