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Obstetric violence: women's knowledge and experiences in prenatal care

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Abstract:
Background: To analyze the knowledge and situations of obstetric violence experienced by women in prenatal care.
Materials and Methods: This is an analytical, cross-sectional and quantitative study carried out in two municipalities in the state of Ceará, Brazil. Participants were 188 women who gave birth in the first quarter of 2022 and answered a questionnaire during that period. Data were tabulated in Excel software, transferred to Epi Info software, version 7.2.5, and submitted to descriptive analysis.
Results: The women's age varied between 18 and 45 years; 122 (64.9%) were married or in a stable relationship; 120 (63.8%) were brown; 71 (37.8%) had completed elementary school; 143 (76.1%) had no employment relationship and declared themselves Catholic; 89 (47.4%) had an income below the minimum wage; and 153 (81.4%) of them did not have supplemental health insurances. The obstetric history revealed that 66 (35.1%) women had a pregnancy, 120 (63.8%) of them did not plan the pregnancy and 133 (70.7%) reported having had at least one cesarean section. The sources of information consulted by 94 (50%) women about obstetric violence were websites/social networks. Contempt, humiliation, threat and neglect by health professionals in prenatal care were the types of violations that 153 (81.4%) of them most recognized.A total of 98 (52.1%) women experienced obstetric violence in prenatal care, with 29 (15.4%) receiving information with poorly accessible language and 11 (5.8%) having neglected care.
Conclusion: Information is the basis for recognizing situations of exposure to obstetric violence and their preventive and protective measures.
Keywords: Obstetric violence; Pregnancy; Primary Health Care.

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I. Introduction

Prenatal care aims to promote maternal and child health, prevent diseases, injuries and complications during the pregnancy and puerperal cycle, and develop assistance for a healthy pregnancy[1].

In prenatal care, professionals from the Family Health Strategy (FHS) team must consider clinical care and educational activities, always considering psychosocial, cultural and economic aspects of pregnant women and their families, in order to guarantee access fair and free from discrimination[2].

In consultations, it is imperative that these professionals address issues related to pregnancy, labor, childbirth and the puerperium, to enable empowerment over information and self-care in an effective and safe way. It is also important to promote listening to clarify doubts, exchange experiences and knowledge, create bonds and critical learning to face adversity[1].

Obstetric violence is one of these adversities that is defined as any conduct, act or omission performed by health professionals from a public or private institution, which causes the undue appropriation of women's bodily and reproductive processes during pregnancy, childbirth, postpartum, or miscarriage care[3].

Obstetric violence can be a result of institutional violence resulting from inhuman social relations, hierarchical rigidity in the relationships between health professionals and patients, failures in the communication process, inappropriate technology use and lack of commitment by professionals to the care process[4].

Examples of obstetric violence in prenatal care are cases in which pregnant women are unnecessarily induced during consultations to have cesarean section, when they are judged by health professionals regarding the number of children, when they are subjected to unnecessary procedures[5]. In childbirth, it is characterized when physical, verbal and/or psychological abuse occurs, disrespect for privacy and freedom of choice, performance of coercive or non-consensual procedures[6]. In the puerperium, obstetric violence is considered when there is omission of information, dehumanized support for breastfeeding, detention of puerperal women and their newborns in health institutions without clinical indication, information provided in poorly accessible language, blame, humiliation and abandonment[7]. It is considered that some of these violations may occur at any stage of pregnancy and puerperal cycle.

Thus, prenatal care becomes a fundamental space for carrying out educational activities on how to prevent verbal, physical, psychological and institutional obstetric violence, in addition to identifying them in the history of previous and current pregnancies[1].It is important to recognize that this theme should be considered by health professionals in prenatal care and among social, political, academic and institutional segments, due to the complexity and magnitude of registered and underreported cases in the country[5].

From this perspective, some Brazilian states created and approved state laws that provide for the implementation of information and protection measures for pregnant women and women in labor against obstetric violence, therefore, until now, there is no specific federal law[8-12].

Other health policies also seek to ensure this unique moment for women, such as the Brazilian National Humanization Policy (PNH - *Política Nacional de Humanização*), the Prenatal Care and Birth Humanization Program (PHPN - *Programa de Humanização do Pré-Natal e Nascimento*) and the Maternal and Child Network (RAMI - *Rede Materno e Infantil*),whose main objectives are to face the challenges regarding quality and dignity in health care, the proposal to reduce the high rates of maternal, perinatal and neonatal mortality in the country, and the reduction of cases of obstetric violence[13-15].

The dissonance is that, despite the existence of preventive and protective guiding documents, there are cases of obstetric violence that begin during the prenatal period and are delayed until the postpartum period;therefore, it is necessary to identify them to punish the perpetrators as well as to give women access to guidance so that they can make assertive decisions when they happen or when they are at risk of violations.

Disseminating through scientific studies what women know about this subject and the situations they experienced in prenatal care could be the initial step to identify the most common types of occurrences in the gestational period and to develop educational strategies to prevent other similar cases from happening, which justifies the present study. Therefore, this study aimed to analyze the knowledge and situations of obstetric violence experienced by women in prenatal care.

II. Material And Methods

Study Design:analytical, cross-sectional and quantitative.

Study Location: two municipalities in the state of Ceará, Brazil, which have more than 350,000 inhabitants and have a Maternal and Child Care Network with three levels of health care, referral and counter-referral services of the Unified Health System (SUS – *Sistema Único de Saúde*) and a network private with obstetricians.

Study Duration: January to May 2022.

Sample size: The study population consisted of women residing in the research locus municipalities who had childbirth in the first quarter of 2022.

Sample size calculation: The sample was calculated with the aid of Openepi statistical program, version 3.01, considering a sample size of 809 live birth certificates (LBC) from the respective municipalities, in this time frame. The LBC were adopted to delimit the sample size, as it was the document provided by the municipal health departments, for access to information on women who gave birth during this period.

Subjects & selection method: A total of 188 women participated in the study, after being delimited by the sample calculation, which considered a sampling error of 5% and a 95% confidence estimate.

Inclusion criteria:

1. Having received prenatal care, childbirth and/or puerperium in public and/or private services in the municipality locus of the research).
2. Being at least 18 years old.

Exclusion criteria:

1. Cases in which women left the data collection instrument with incomplete answers.

Procedure methodology

A questionnaire was applied that included sociodemographic data, obstetric history, knowledge and experiences about obstetric violence, after they signed the Informed Consent Form (ICF), from January to May 2022.

Statistical analysis

After collection, data were tabulated in Excel software, transferred to a public domain software called Epi Info, version 7.2.5, developed by the Centers for Disease Control and Prevention (CDC)[16] and submitted to descriptive analysis. The study was approved by the Research Ethics Committee, under opinion number 5,168,808.

III. Result

Table 1 presents participants sociodemographic characteristics according to variables age, marital status, racial self-declaration, education, employment relationship, occupation, family income, religion, residential area and supplemental health insurance.

Table1–Research participant sociodemographic characteristic. Ceará, Brazil, 2022

	Frequency	**%**
Age (years)		
18-24	67	35.6
25-34	101	53.7
35-45	20	10.7
Marital status		
Married/stable union	122	64.9
Single	62	33.0
Divorced	4	2.1
Racial self-declaration		
Yellow	5	2.7
White	32	17.0
Indigenous	2	1.1
Black	29	15.4
Brown	120	63.8
Education		
Complete elementary school	23	12.3
Incomplete elementary school	34	18.1
Complete high school	71	37.8
Incomplete high school	15	7.9
Complete higher education	15	7.9
Incomplete higher education	19	10.1
Graduate education	11	5.9
Employment relationship		
No	143	76.1
Yes	45	23.9
Occupations		
Health professionals	11	5.8
Teacher	6	3.2

Commerce workers	28	14.9
Autonomous	12	6.4
Housewife	107	56.9
Others	24	12.8
Family income		
Less than minimum wage	89	47.4
From 1 to 2 minimum wages	83	44.1
Greater than 2 minimum wages	16	8.5
Religion		
Candomblé	1	0.5
Catholic	143	76.1
Spiritism	2	1.1
Evangelical	31	16.5
No religion	10	5.3
Other	1	0.5
Residential area		
Urban area	154	81.9
Rural area	34	18.1
Supplemental health insurance		
No	153	81.4
Yes	35	18.6

Source: The authors, 2022.

In total, 188 women aged between 18 and 45 years old participated in the survey, of which 101 (53.7%) were aged between 25 and 34 years old, 122 (64.9%) women were married or had a stable relationship with partners, 120 (63.8%) self-declared brown (Table 1).

All participants reported some level of education, but 71 (37.8%) had completed elementary school and 11 (5.9%) had a graduate degree. A total of 143 (76.1%) women did not have an employment relationship, but reported different occupations,as 107 (56.9%) were housewives, 28 (14.9%) worked in commerce, 12 (6.4%) declared themselves self-employed, 11 (5.8%) health professionals, six (3.2%) teachers and the remaining 24 (12.8%) women reported different types of occupation. Through these occupations added to those of family members who lived in the same house, a total income of less than one minimum wage among 89 (47.4%) women (Table 1).

With regard to religion, 143 (76.1%) declared themselves Catholic and 154 (81.9%) women lived in the urban area. Furthermore, 153 (81.4%) of them did not have supplemental health insurance and their health care came exclusively from services linked to SUS (Table 1).

Table 2 describes participants' obstetric history according to the following variables: number of pregnancies; age at first pregnancy; if the first pregnancy was planned; vaginal childbirths; cesarean sections; miscarriage; complications in the last pregnancy; intercurrences mentioned.

Table2 - Research participants' obstetric history. Ceará, Brazil, 2022

	Frequency	**%**
N° of pregnancies		
1	66	35.1
2	62	33.0
3 or more	60	31.9
Age at the first pregnancy		

Under 18 years old	42	22.3
Between 18 and 24 years old	100	53.2
Between 25 and 34 years old	40	21.3
Between 35 and 45 years old	6	3.2
First pregnancy planned		
No	120	63.8
Yes	68	36.2
Vaginal childbirths		
0	99	52.7
1	55	29.3
2	17	9.0
3 or more	17	9.0
Cesarean sections		
0	55	29.2
1	72	38.3
2	47	25.0
3 or more	14	7.5
Miscarriages		
0	154	81.9
1	28	14.9
2	5	2.7
3 or more	1	0.5
Intercurrences in the last pregnancy		
No	137	72.9
Yes	51	27.1
Intercurrences mentioned		
Bleeding	6	11.8
Infection	8	15.7
Pre-eclampsia	16	31.4
Diabetes	4	7.8
Hypertension	7	13.7
Placental abruption	2	3.9
Others	8	15.7

Source: The authors, 2022.

The number of participants' pregnancies was approximate, as 66 (35.1%) had one pregnancy, 62 (32.9%), two, 60 (31.9%), three or more. Furthermore, 100 (53.2%) of them became pregnant between 18 and 24 years of age; 120 (63.8%) women did not plan their pregnancy; 89 (47.3%) women experienced at least one vaginal childbirth; 133 (70.7%) reported having had at least one cesarean section. Of the total, 154 (81.9%) had no history of miscarriages (Table 2).

Regarding intercurrences during pregnancy, 137 (72.9%) did not report any type of intercurrence in their last pregnancy. Among those who had complications, hypertensive syndromes during pregnancy were the most prevalent, with reports of 16 (31.4%) women with preeclampsia and seven (13.7%) with specific hypertensive disease of pregnancy (hypertension) (Table 2).

In Table 2, with regard to the aforementioned intercurrences, called others, situations of hydronephrosis, threat of pre-mature labor, COVID-19,decreased amniotic fluid, gestational diabetes, symptomatic varicose veins, insomnia, placental abruption, circulatory disorders, gallbladder crisis, and early placental calcification.

Table 3 presents study participants' knowledge on obstetric violence through the sources of information used by them and the recognition of the types of violence that may occur in prenatal health services.

Table 3 – Participants' knowledge about obstetric violence. Ceará, Brazil, 2022

	Frequency	**%**
Sources of information used by women on obstetric violence*		
Health professionals	32	17.0
Family friends	45	23.9
Websites/social networks	94	50.0
Television/newspapers/magazines	45	23.9
Folders/booklets	7	3.7
Preparatory course for pregnancy, childbirth and postpartum	7	3.7
I never tried to find out about obstetric violence	68	36.2
Recognize situations of obstetric violence that can occur in health services during prenatal care*		
Denying care to pregnant women	147	78.2
Refusing hospitalizations when the pregnant woman needs it	108	57.5
Preventing companions from asking questions about the pregnancy	76	40.4
Preventing companions from entering the prenatal care consultation	66	35.1
Not allowing pregnant women to clarify doubts	93	49.5
Preventing companions from entering laboratory and complementary exams	61	32.5
When health professionals do not explain the purpose of tests	63	33.5
Pregnant women being induced in consultations for cesarean section unnecessarily	87	46.3
Negligence during prenatal care	113	60.1
Physical, verbal and/or psychological abuse	141	75.0
Disrespect for privacy and freedom of choice	115	61.2
Carrying out unnecessary procedures	97	51.6
Women being judged by health professionals regarding the number of children	87	46.3
Omission of information	88	46.8
Information provided in poorly accessible language	65	34.6
Contempt, humiliation, threat and neglect by health professionals	153	81.4

*The participant could choose more than one option.
Source: The authors, 2022.

Table 3 revealed that the sources of information consulted by 94 (50%) women on the subject were websites/social networks, as opposed to 68 (36.2%) who did not seek this type of knowledge, which could leave them in situations of vulnerability to violations.

As for recognition of situations of obstetric violence that can happen in health services in prenatal care, the one that was most representative was situations of contempt,humiliation, threat and neglect by health professionals, stated by 153 (81.4%) women. Then, 147 (78.2%) women understand that denying care to pregnant women is a form of violation during pregnancy (Table 3).

It was observed that most of them were unaware that the presence of a companion is also an obstetric right and that it could be violated by health professionals. This result was evidenced when only 76 (40.4%) women recognized that preventing their companions from asking questions about pregnancy during prenatal care is a violation, just as 66 (3.1%) and 61 (32.5%) women knew that preventing their companions from entering the prenatal care consultation and during laboratory and complementary tests, respectively, are also considered violations of pregnant women's rights(Table 3).

Table 4 presents situations of obstetric violence experienced by women in prenatal care, namely: service denied in the health service during prenatal care; neglected prenatal care; presence of physical, verbal, psychological abuse; disrespect for privacy during prenatal care; performing unnecessary procedures; professionals prevented their companions from entering the consultation;health professionals did not clarify doubts and did not allow companions to clarify; induction during consultations to cesarean section unnecessarily; information received in poorly accessible language; humiliation by health professionals.

Table 4 - Situations of obstetric violence experienced by research participants. Ceará, Brazil, 2022

	Frequency	**%**
Service denied in health service during prenatal care		
Yes	9	4.8
No	179	95.2
Neglected prenatal care		
Yes	11	5.8
No	177	94.2
Presence of physical abuse during prenatal care		
Yes	2	1.1
No	186	98.9
Presence of verbal abuse during prenatal care		
No	188	100
Presence of psychological abuse during prenatal care		
Yes	1	0.5
No	187	99.5
Disrespect for privacy during prenatal care		
Yes	3	1.6
No	185	98.4
Performance of unnecessary procedures		
Yes	5	2.7
No	183	97.3
Professional prevented their companions from entering the prenatal care consultation		
Yes	3	1.6
No	185	98.4
Health professionals did not clarify doubts		
Yes	15	7.9
No	173	92.1
Professionals did not allow their companions to clarify doubts		
Yes	5	2.6
No	183	97.4
Unnecessarily inducing a cesarean section		
Yes	10	5.3
No	178	94.7
Information received in poorly accessible language		
Yes	29	15.4
No	159	84.6
Humiliation by health professionals		
Yes	5	2.6
No	183	97.4

Source: The authors, 2022.

Of the total of 188 women who participated in the study, 98 (52.1%) reported having experienced some type of obstetric violence in prenatal care. Of these, nine (4.8%) women were denied care at some health service during prenatal care; 11 (5.8%) had neglected care; two (1.1%) suffered physical abuse; one (0.5%) mentioned having suffered psychological abuse; three (1.6%) had their privacy violated; five (2.6%) underwent unauthorized procedures; three (1.6%) were prevented from having a companion in the consultation; 15 (7.9%) said that health professionals did not clarify doubts; and five (2.6%) said that their companion's doubts were not clarified (Table 4).

Of the total number of women who participated in the study, 10 (5.3%) reported that they were unnecessarily induced during consultations to have a cesarean section; 29 (15.4%) of them said that the information received was in poorly accessible language; and five (2.6%) reported that they were humiliated by health professionals (Table 4).

IV. Discussion

Studies and discussions on obstetric violence have increased in recent decades. However, researchers interested in the subject are particularly faced with violations that occurred in hospital environments, and the present study aims to highlight what participants knew about the subject and the violations that occurred during prenatal care.

Woman sociodemographic characteristics in this research are similar to a study that aimed to analyze pregnant women's knowledge about their health and it turned out that, of the 264 participants, the majority belonged to the age group of less than or equal to 34 years (68.9%), 81.8% were married or had a stable relationship, 86.7% were Catholic and 62.5% lived in an urban environment[17].

Participants' average level of education was also evidenced in a study carried out in a coastal lowland region of the state of Rio de Janeiro in 2018, in which 33 women who had suffered obstetric violence were interviewed[18].

Although it is assumed that the less education, younger age and unplanned pregnancy, the less women's knowledge about obstetric issues, consequently, the greater the obstetric violence cases[19].The results of this study showed that women who had a good level of education, adulthood and stable relationships, most had records of obstetric violence, a fact that demonstrates the need to approach the subject for all ages and school profiles.

The skin color variable also influences obstetric violence, as brown and black women are more likely to suffer racial prejudice, showing themselves to be more vulnerable to violations[20].

With regard to health insurance use, it is evidenced that women who depend on SUS become pregnant at an earlier age and in an unplanned way when compared to women who have a supplemental health insurance, due to income and occupation[21], as also happened in the present study.

The sociodemographic characteristics described when associated with participants' obstetric history raised the need to analyze their prior knowledge about obstetric violence,for a triangulation of information that helped to identify the knowledge and experiences on the subject. In this study, women sought different sources to acquire this type of knowledge, highlighting internet use, as it has been the most used means of communication in recent years.[22].

Through individual knowledge acquired by information sources, they recognized the main situations of obstetric violence that can happen in health services during prenatal care, which facilitated the prevention or identification of violation that occurred in the current pregnancy by most participants.

Verbal violence and different types of negligence were described by participants as forms of violence in prenatal care,which suggests that they have already experienced these types of violations at other times that they needed the health service and were able to identify it in the current pregnancy. However, most failed to realize that they have the right to have companions during prenatal care, perhaps because they feel that their presence is unnecessary or an impediment to health services.

The World Health Organization (WHO) recommends the presence of a pregnant woman's companion in health services as one of the actions that aim to contribute to better maternal and neonatal outcomes, reduce unnecessary interventions and avoid obstetric violence[23].

For women who are unaware of this and other rights and those who reported that they do not seek information sources on the subject, it is recommended that health professionals pay more attention during prenatal consultations as they are opportune moments for them to demystify expectations, clarify doubts and avoid violations[24].

This study showed that most participants experienced obstetric violence in different ways during the current pregnancy, highlighting the inaccessible language adopted by professionals as the main violation, which possibly caused doubts and generated other violations during prenatal care.

When there is no understanding of technical language about prenatal care, doubts and concerns arise and leave women in a vulnerable situation. Therefore, adequate communication and information are the main tools for the success of care results and violation reduction[25].

There is much to advance in relation to scientific research that investigates obstetric violence in pregnancy and puerperal cycles, as it is necessary to understand the concepts emitted by women, the occurrence of this phenomenon and the preventive elements of new cases[26].

V. Conclusion

The study analyzed the knowledge and violations that occurred in prenatal care in women who had recently experienced motherhood and whose main outcome was the need for more information than what they previously had.

Information is the basis for recognizing situations of exposure to obstetric violence and their preventive and protective measures. Thus, it is recommended that the subject be contemplated during prenatal care on an ongoing basis so that maternal and child health is promoted without risks and intentional damage.

It is suggested that further research be encouraged on this topic that can impact health insurance and that can serve as subsidies for planning public policies aimed at tackling this phenomenon, which is real and at the same time made invisible by society.

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